

The Sociocultural Factors of Therapy Choice – Circumstances of Complementary and Alternative Medicine Use among Hungarian Patients

Doctoral thesis

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INTRODUCTION

Topic of research

This dissertation concerns sociocultural factors underlying the therapy choice of patients using non-conventional healing modalities, that is, Complementary and Alternative Medicine (CAM). In a larger context, the research focused on how patients encounter healthcare-related information, how they interpret it, and how their interpretation is manifested in behavior. Specifically, users of Traditional Chinese Medicine (TCM) were scrutinized, yet the observation of phenomena connected to TCM offers a high level of transferability to other CAM modalities.

Clinical relevance

Employing non-conventional modalities as an alternative to biomedicine (forgoing biomedical treatment), as opposed to supplementing it (complementary use), often occurs in relation to life-threatening disease as well. Furthermore, it is common for the patient to not disclose their decisions regarding complementary methods to the attending physician, which may lead to harmful interactions among employed therapies. Difficulties in communication may arise from the doctor not knowing of or being open to understanding patient motivations underlying CAM use, as well as their personal and cultural preferences. This frequently results in a loss of trust in the physician.

Definitions

CAM is often defined as non-conventional treatments, yet what is considered “conventional” and its delimitation may vary not only among countries, but even among hospitals. The Cochrane Collaboration’s definition of CAM directs attention to the fact that most CAM modalities are medical systems embedded within a larger culture and that the very definition of CAM (and of conventional medicine) is dependent on the dominant medical system of the given country.

Prevalence

Most studies report increasing CAM use, albeit data gathered internationally is not easily compared; their interpretation is subject to the given healthcare system (sectors, modalities covered by social security, etc.), the definition of CAM employed in the study (e.g. only examining the use of “biologically-based” CAM, systems of medicine, specialists, or products), the categorization of CAM (e.g. based on a law that regulates them, a typology created by an international organization, or criteria for being evidence-based), the illness group (e.g. “lung cancer” or “chronic” or

“musculoskeletal” represent different approaching in defining a sample), the type of CAM use (e.g. parallel to or instead of biomedicine), and so on.

The “typical” CAM user

Many researchers concluded that the typical CAM user is a middle-aged, wealthy, well-educated, Caucasian female most likely suffering from cancer. Other authors assert that demographic variables do not play a determining role in health and illness behavior specific to CAM use and place a greater emphasis on psychological constructs and sociocultural determinants.

Therapy choice

One theory explaining the popularity of CAM is the “market niche” hypothesis: non-conventional modalities are strong where the patient perceives biomedicine to be lacking, such as providing care and giving meaning to suffering. Another theory takes a dichotomized approach: there are “push factors” repelling the patient from biomedicine (e.g. there is no conventional cure, the cure is not effective or its side-effects are too intense) and “pull factors” drawing the patient to CAM (e.g. philosophical congruence, that is, the patient identifies with the sociocultural environment and values of a certain CAM modality). Similarly to the push-pull dichotomy, many authors differentiate between “dissatisfaction/disappointment” on the one hand, and “beliefs/values” on the other, asserting that the latter has a more substantive role in CAM use. Thus, conceptual and behavioral patterns can play a significant part in predicting choice of therapy. There are a number of psychological constructs that exhibit a positive correlation with CAM use, such as positive thinking, optimism, holism, self-efficacy and agency, yet the instruments utilized in various studies may differ in how they define these constructs. The findings of such studies may also be deemed decontextualized as research designs rarely take into account the broader political, sociocultural, historical or sociopsychological phenomena, even though they influence individual cognition and behavior to a great extent. An in-depth understanding of CAM use stems from keeping individual attitudes in their sociocultural context while scrutinizing micro and macro level phenomena collectively. Congruently, it is important to explore how patients think about the world, man, illness, and health (i.e. their explanatory model), and investigate cultural dispositions that determine their decisions regarding healthcare issues.

Explanatory Models (EM)

A preconception of the present research was that therapy choice is related to the patient's concepts of world, society, man, illness and health, which together constitute their EM. Any given medical system also has an EM; the practitioner and patient interpret their experiences according to their EM and refine their EM based on their experiences. This model influences how a patient perceives their complaints, symptoms, and is in strong interaction with their illness behavior, self-care, help-seeking behavior, trusted sources of information, adherence to a treatment, and coping with disease.

OBJECTIVES

- ✓ The main objective of the research was to explore and expound on sociocultural factors and cognitive patterns underlying CAM use, and to convey these findings primarily to the medical community.
- ✓ A clinically relevant objective of the initiative was to pinpoint challenges in doctor-patient communication concerning CAM use and to present those from the viewpoint of the patient. Congruently, a further goal was to make recommendations to doctors regarding communication within this domain.
- There was no intention for this project to measure CAM use or prevalence in any of its subtopics, as the research objectives did not call for it and the methods employed did not enable this. Furthermore, it is not a research goal to “objectively” or “subjectively” assess the effectiveness of CAM modalities or to create a typology of non-conventional treatments.
- The researcher does not wish to evaluate CAM use in any way or arrive at any value judgements regarding the relationship between CAM and biomedicine. It is the author's strong conviction that neutrality, reflexivity, and a critical stance are indispensable for generating reliable findings.

METHODS

The present research initiative was an exploratory, qualitative research project founded on two components: participant observation and semi-structured interviews. Securing the anonymity of participants involved in the study through the fieldwork was a high priority.

Participant observation (Jan. 2015 – May 2017)

Aims: „Immersing” oneself in the field, observing phenomena in their naturalistic setting, participating in everyday activities.

Sampling: Convenience sampling was employed with temporal saturation. The fieldwork sites (TCM clinics) and practitioners (TCM doctors) were included via non-proportional quota sampling stratifying on the following: 1) Attitudinal and education typology of practitioners (maximum variability), 2) Geographical location of clinic (Buda and Pest), 3) Nationality of practitioner (Hungarian and Chinese), and 4) Sex of practitioner (male and female).

Semi-structured interviews: practitioners (Jan. 2015 – June 2017)

The 1.5-2-hour interviews were conducted at the practitioners' clinic, were sound-recorded and transcribed verbatim.

Interview structure: Thematic blocks of questions and prompts without a set order; participants could diverge from topics to a certain extent; each interview encompassed every topic: career choice (physician, TCM practitioner, relation to biomedicine), concepts of world (ontology and epistemology), relationship to majority society and values, concepts of man (constituents and their interplay), concepts of illness (definition/description, etiology, nosology), concepts of health (definition/description, process of healing).

Sampling: Non-proportional quota sampling (see above); participants were recruited from fieldwork sites and other TCM clinics.

Semi-structured interviews: patients (Jan. 2015 – June 2017)

The 1.5-2-hour interviews were conducted in accordance with the interviewee's choice: at the clinic the patient frequented, the patient's home, or a public place. Interviews were sound-recorded and transcribed verbatim.

Interview structure: Thematic blocks of questions and prompts without a set order; participants could diverge from topics to a certain extent; each interview encompassed every topic: patient journey (why TCM, other employed CAM modalities, manner of coming into contact with modality, subjective evaluation of treatments), concepts of world (ontology and epistemology), relationship to majority society and values, concepts of man (constituents and their interplay), concepts of illness (definition/description, etiology, nosology), concepts of health (definition/description, process of healing).

Sampling: Non-proportional quota sampling; participants were recruited from fieldwork sites and other TCM clinics. Stratification based on: 1) Nationality of patient (only Hungarian), 2) Sex of patient (male and female), and 3) Location of recruitment (maximum variability).

The coding process

Phase 1: Free (inductive) coding performed by the researcher, codes remained dynamic for one third of the duration of fieldwork.

Phase 2: A tentative coding system was developed containing two code trees: PJ (Patient Journey) and EM (Explanatory Model). PJ and EM code trees were used to deductively re-code the data collected during the first phase and all data collected after this point (from participant observation and patient interviews).

Phase 3: After the fieldwork terminated, two raters working autonomously performed free (inductive) coding on the anonymized raw data and developed separate code systems for coding patient journeys and disclosed EMs.

Phase 4: Triangulation was performed on the three code systems (those of the two independent raters and the researcher), differences in coding were negotiated until consensus was achieved.

Phase 5: The final version of the PJ and EM code trees was developed.

Phase 6: All three raters deductively re-coded the whole dataset with the final version of PJ and EM codes, then triangulated the results.

Atlas.ti 6.0 software was used in all phases of coding, each rater's data received a separate hermeneutic unit within the program.

The code trees

The PJ (Patient Journey) code tree comprises aspects of the patient journey related to therapy choice, specifically, at what point the patient began using CAM and with what explicit reason. The patient journey includes the following main (parent) codes: diagnosis (PJ.D), consultations (PJ.C), treatment (PJ.T), and at any point (PJ.A). The four parent codes contain a total of 15 children and 8 grandchildren, thus constituting three levels of abstraction.

The EM (Explanatory Model) code tree comprises aspects of the patient's explanatory model. Explanatory models include the following main (parent) codes: concepts of world (EM.W), relation to society (EM.S), concepts of man (EM.M), concepts of illness (EM.I), and concepts of health (EM.H). The five parent codes contain a total of 33 children and 117 grandchildren, thus constituting three levels of abstraction.

Analysis

Narrative analysis was performed with Interpretative Phenomenological Analysis, which is an analytic system that guides inductive coding from emergent codes to higher levels of abstraction through merging, resulting in the final steps where parent codes can be generated.

RESULTS

Participant observation spanned a 29-month period from Jan. 2015 to May 2017 at four sites: two TCM clinics with a sole practitioner and two TCM clinics where multiple practitioners worked (details shown below).

Table 1: Details of participant observation

Duration	Jan. 2015 – May 2017 (29 months)
Site	4 TCM clinics (2 Buda, 2 Pest)
Main practitioner of clinic	2 Hungarian, 2 Chinese; 2 females, 2 males; mean age: 48 (range: 33-61 years)
Mode of inclusion	Admitted N=49; Treated N=56 (total N=105)
Prior biomedical testing?	Yes N=90 (85.7%) No N=15 (14.2%)
Received biomedical diagnosis?	Yes N=66 (62.8%) No N=39 (37.1%)

Eighteen female and 10 male patients were suffering from musculoskeletal illnesses, while the second most prominent illness in the sample was cancer, various types treated as one nosological category (7 females, 12 males). Furthermore, there was a pronounced presence of gastrointestinal complaints and diseases (10 females, 6 males), as well as gynecological and prostate problems (9 females, 5 males). For women in the sample the most common illness type was musculoskeletal (N = 18), for men it was cancer (N = 12). Semi-structured interviews were conducted with 10 patients (4 males, 6 females), their mean age was 58.6 years. The table below displays the demographic information of patients and practitioners involved in the study.

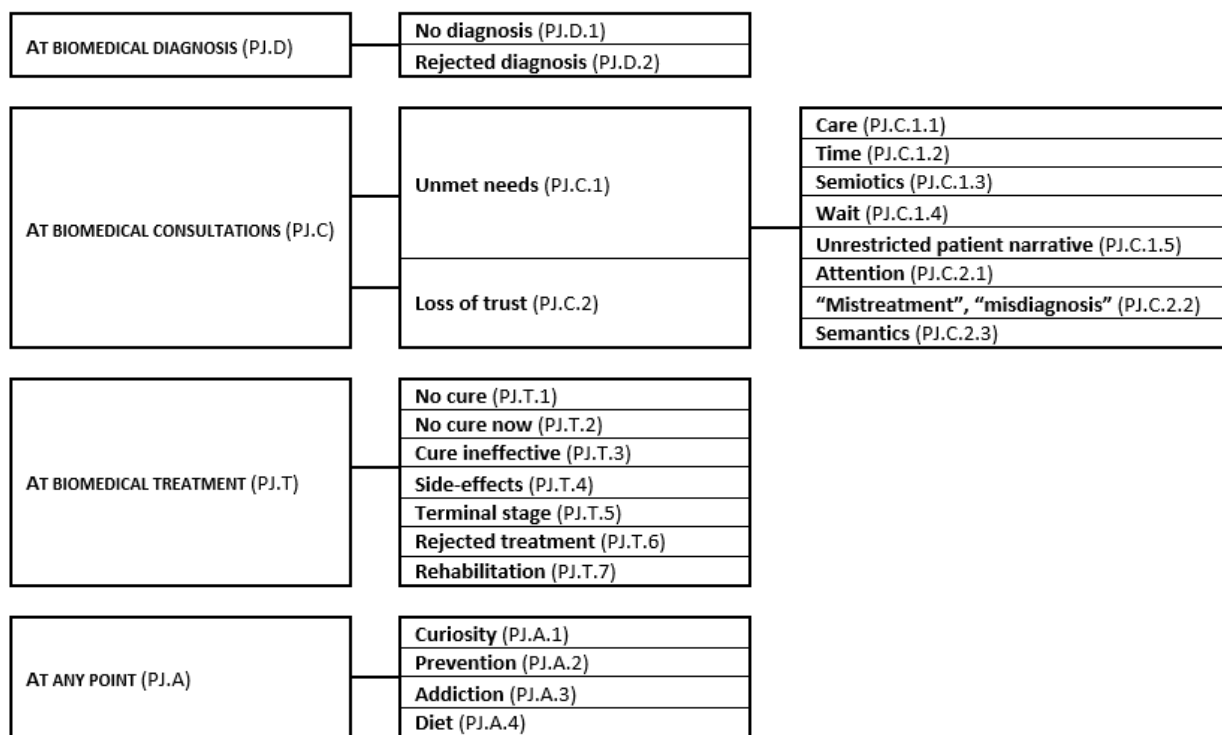
Table 2: Cumulative demographics

	SEMI-STRUCTURED INTERVIEWS		PARTICIPANT OBSERVATION
	Patients (N=10)	Practitioners (N=10)	Patients (N=105)
Sex	M: N=4; F: N=6	M: N=5; F: N=5	M: N=42; F: N=63
Mean age (yrs)	58.6 (range: 26-78)	50.1 (range: 35-83)	53.3 (range: 2-85)
Place of residence	Capital N=5 County seat N= 1 Town N=4	Capital N=10 Buda N= 5 Pest N=5	Capital N=75 County seat N= 8 Town N=22

The PJ code tree (points of entry into CAM)

The function of PJ codes is to elucidate when patients started using TCM as a complementary or alternative treatment during their patient journey and for what explicit reasons. The order and steps in the patient journey below were not identical for all, but all CAM-use disclosures from patients could be coded with one or more of these codes. Below is the entire code tree, which emerged from patient narratives:

Figure 1: The PJ code tree



Concerning biomedical diagnosis (PJ.D), two main phenomena were recorded in the ethnographic data: despite extensive biomedical testing, the patient received no diagnosis for their (functional) condition or the patient rejected the diagnosis. CAM use commencing at the point of biomedical consultations (PJ.C) occurred because of patient dissatisfaction and loss of trust in the doctor-patient relationship (e.g.: lack of attention or care). Patients employed CAM modalities during biomedical treatment (PJ.T) because the conventional therapy was not effective, its side-effects were too intense, or they were desperate to try anything that would heal them. The codes under parent PJ.A signify points of entry into CAM that were independent of the patient journey or could occur at any time, such as curiosity, prevention, or addiction.

The EM code tree (explanatory model)

The most important preconception of the research was that a patient's choice of therapy interacts with their explanatory model. An EM typology emerged inductively from the ethnographic material with the following categories: immune-, nutrition-, ecology-, psychosocial-, and vitalist-emphatic EM. The typology is an analytic category system, thus individual patients have EMs that are comprised of one or more of these categories, in varying intensities. Below is a brief overview of the EM typology structured according to EM parent codes (world, society, man, illness, health).

Immune-emphatic

Concepts of World: In this EM category, the individual believes they inhabit a polluted world (“*there are harmful chemicals everywhere*”) that is governed by hostile forces. Among metaphors of attack and defense, the immune system – identified with protection – plays a significant role in “*fighting*” and “*overcoming*” pathogens.

Relation to Society: According to this EM, the immune system is hindered by urbanization, an overstrained lifestyle, and chemicals found in products offered to consumer society. Man-made environments are negatively appraised in this EM, as the surroundings humans create end up “*attacking*” them by causing illness.

Concepts of Man: In such an environment, one needs a strong line of defense, which is provided by the immune system conceptualized as a shield protecting the Self. This system is thought of as separate from the body, albeit located inside of it; its state is appraised on the axis of “*weak-strong*” depending on how well it is “*fighting against enemy*” forces.

Concepts of Illness: Etiologies connected to the immune system can be grouped under two main notions: the immune system is underactive/overactive or it attacks itself. Emotional or physical exhaustion, or a build-up of chemicals leads to an underactive (weak) immune system. If the immune system is overactive, it is exhibiting an “*excessive reaction*” (over-reacting), as in the case of an allergy. Self-attack is usually employed as a theory of autoimmune disease causation.

Concepts of Health: The immune system is inherently strong and several things may contribute to strengthening it such as sufficient rest and sleep, a healthy diet, exercise, a healthy living environment, etc. Patients with an immune-emphatic EM usually employ CAM to enhance “*natural, self-healing mechanisms*” and strengthen their immune system.

Possible reasons for rejecting conventional treatment: non-selective procedures should be avoided; radiation therapy further weakens a weak immune system.

Nutrition-emphatic

Concepts of World: Similar to the immune-emphatic EM, the individual feels they are living in a polluted world, but the effects of “*chemicals*” and “*toxins*” are primarily associated with food.

Congruently, the patient tries to maintain a sense of cleanliness through food as well. Pollution traverses into the body with agents such as “*additives*” described as “*synthetic*” and “*artificial*”; while the cultural opposites of these “*chemicals*” are e.g. “*additive-free*”, “*organic*”, and “*natural*”.

Relation to Society: Rejecting any of the following values accredited to the majority society may be central to this EM: consumer society, mass-production, fast-food, and use of artificial additives.

Identifying with these is thematized as a rebellion against majority society: sustainable development, organic products, organic farming, home remedies, and traditional remedies.

Concepts of Man: The nutrition-emphatic EM predominantly identifies humans with their body. The health and maintenance of the body is crucial and is intertwined with diet: “*you are what you eat*”.

Concepts of Illness: In this EM, illness is caused by “*toxins*” entering the body (especially via food and drinks) and accumulating within. Among patient narratives, “*bad nutrition*” as etiology frequently co-occurred with other theories of illness causation, mainly ecological etiology (see below).

Concepts of Health: In this EM, a healthy diet contributes to health and healing greatly. The products, agents of biomedicine (e.g. pharmaceuticals) bear negative associations, yet CAM products (e.g. herbs, nutritional supplements) are appraised positively. The concept of “*detoxification*” plays a significant part in the healing process.

Possible reasons for rejecting conventional treatment: pharmaceuticals are toxic; chemotherapy is poison; medication causes addiction.

Ecology-emphatic

Concepts of World: The world is seen as a polluted, filthy place – there are toxins in food, drinks, and the environment (water, air, etc.). However, the world is not inherently dirty, it is being polluted by individuals or groups with malintent, people are negligent at the expense of others, or the zeitgeist itself is spawning such behavior. Hence, the world is not a safe place. Malintent is aptly illustrated with the notion of the “*chemtrail*”: condensation trails left behind by airplanes; these are believed to be deliberate poisoning.

Relation to Society: Consumerist, interest-driven society forces the individual to make decisions detrimental to their health (in relation to diet, lifestyle, etc.) so that these societal forces can turn a profit. A romanticized past and the negative appraisal of the Anthropocene have a critical role in this

EM: the world and society are not only perceived as showing signs of decline, but also create “unnatural” surroundings and ways of life.

Concepts of Man: The body and the immune system are the most important constituents of man, yet this EM also emphasizes the role of man’s physical and social environment as well.

Concepts of Illness: Ecological etiologies in patient narratives can be placed into three thematic groups: illness is caused by 1) lifestyle (“overburdened”, “overworked”, etc.), 2) toxins in the environment (air pollution, “electrosmog”, etc.), and 3) toxins in toiletries.

Concepts of Health: Health is conceptualized as an ideal environment, like a “pure world” far from the “modern world” in both time and space. It may be a strong conviction in this EM that health (contingent on good living conditions) is only attainable by the wealthy and that average people, vulnerable to societal forces, do not have enough time or money to maintain their health.

Possible reasons for rejecting conventional treatment: „Big Pharma” attitude (pharmaceutical companies and physicians are motivated solely by malintent and financial interests); avoiding pharmaceuticals; anti-vaccination.

Psychosocial-emphatic

Concepts of World: In this EM, the world is defined by social interactions and interpersonal relationships. These interactions have a strong influence on the everyday life of the patient, as well as their physical and psychological state. If these interactions are deemed stressful by the patient, then the world at large is also perceived to be stressful.

Relation to Society: Society is conceptualized as a web of social relations, interactions at the workplace, in the family, among friends, sexual relationships, etc. Since the patient’s social network may be overloaded or weak, the social support CAM offers (at clinics or courses) may play a crucial role in choice of therapy.

Concepts of Man: Three domains emerged from the narratives: environment (social milieu), body, and a third constituent identified in various ways (psyche, soul, spirit, consciousness, etc.). These constituents exhibit an asymmetrical relationship with one another. In the intrapersonal realm, the psyche has a greater influence on the body than vice-versa; in the interpersonal realm, the environment has a greater influence on the individual than vice-versa. The nervous system may have a prominent role as nerves are subject to wear and tear, eventually leading to illness.

Concepts of Illness: Interpreting the cause of illness (as applied to social relationships) is important to the patient with this EM. Meaning-making is dominated by lay interpretations of psychological notions. Often the individual remains in a passive role or experiences helplessness in the face of the

“*emotional conflict*” to which they accredit their illness. Meaning-making is usually less prominent than emphasizing stressors.

Concepts of Health: Health is chiefly identified with a “*good mood*” or a “*peace of mind*”, and “*stability, harmony, balance*” do not only signify emotional well-being but physical health as well. The process of healing is often equated with the removal of the stressor(s) or with resolving the intra- or interpersonal conflict.

Possible reasons for rejecting conventional treatment: forgoing medicine because it only targets the “*symptom and not the cause*”; postponing seeking help because “*working on self*” or wants to “*solve things*” on their own.

Vitalist-emphatic

Concepts of World: A “*universal energy*” gives rise to all things in existence; this energy makes reincarnation possible and maintains karma, a system based on moral cause and effect. Problems in the present are the consequences of acts committed in the past. This belief is that in every life we live, we consciously choose what we undertake, “*attracting*” people and events, which help us “*grow, develop*”; “*nothing happens by chance*”.

Relation to Society: Society is conceptualized as a Unity or Oneness: “*we are all one*”, “*everything is one*”, “*our consciousness is connected*”; thus, when an individual interacts with another, they encounter themselves, another Self – in this way, each relationship is sacralized. There are “*karmic relationships*”, as we meet the “*same souls again and again*”, provided we still have a “*karmic debt to pay off*”.

Concepts of Man: Usually three constituents are differentiated: body, Ego and Self. There is an “*energy system*” in the body, which may be linked to notions of “*meridians*” and “*chakras*”. The Ego is one’s personality, which is formed in the process of socialization and has a profane connotation, as it is often held responsible for fears and inhibitions. The Self is a “*pure and perfect*” entity, it is eternal and capable of reincarnating, while remaining in direct contact with the (divine) Oneness.

Concepts of Illness: Disease occurs due to an irregular flow of energy (“*block/age*”), which is primarily caused by “*trauma*” acquired in this or a previous life. Illness may also be caused by an inadequate relationship to oneself (or another), such as “*not loving oneself enough*”. Hence, in this EM, physical illness is caused by psychosocial factors.

Concepts of Health: Health is the “*unimpeded flow of energy*” by way of “*clearing the block*”. Healing can only be achieved through “*learning*” or “*growing*” as part of a “*journey of self-discovery*”. “*Learning*” can occur by “*suspending one’s Ego*” and identifying with the sacred Self.

Possible reasons for rejecting conventional treatment: anti-drug attitude if the individual considers “*taking medication*” (i.e. addressing the “*symptom*”) and “*working on themselves*” (i.e. dealing with the “*real cause*”) as mutually exclusive.

CONCLUSIONS

A wide array of conclusions could be drawn from this study, which may be useful for various disciplines; yet in congruence with the objectives, inferences made here aim to further medical communication. Thus, the following will discuss building trust in the doctor-patient relationship, as well as some consequences of losing trust. The conclusions end with a few challenges that should be addressed in the future regarding CAM use.

Aspects of building trust

The importance of trust in the doctor-patient relationship

- The doctor-patient relationship plays a significant role in how the patient evaluates treatment efficacy. According to the results, patients require an increased amount of care and attention; if they perceived these to be lacking, the physician was considered as too „*distant*”. Patients often equated impersonal treatment with being „*treated incorrectly*” in a medical sense.
- When a physician criticizes another doctor’s judgement or questions their competence, this has a negative effect on the patient’s trust toward biomedicine in general. These situations pertain to instances of inter-collegial attack as opposed to giving a second medical opinion (one doctor is reflecting upon another’s conclusions).

Ask, Listen, Answer

- Patients using CAM are afraid of the physician’s condemnation, and thus do not inform the doctor about employing non-conventional therapies. Due to most patients avoiding this topic, it is worthwhile for the physician to initiate the conversation.
- The degree of adherence is highly influenced by whether the patient views treatment as congruent with their theory of illness causation. It is useful to ask the patient at the beginning of the therapeutic process what they think caused their illness, what the disease means to them, which treatments they have heard of and what they expect from these.
- A crucial factor in building trust is that the patient feels they have the opportunity to ask questions about the diagnosis and treatment.

Interpreting the side-effects

Information regarding potential side-effects of the conventional treatment proved very important. This was especially true when the patient, despite having a severe disease, was symptom-free or only experienced mild complaints when initiating the biomedical treatment. If the patient judges their physical or mental condition to be worse than before the treatment, many patients may be deterred from continuing. Ensuing bodily sensations may be interpreted as harmful side-effects or as therapeutic ineffectiveness and patients may lose trust in the treatment. In a worst-case scenario, patients can interpret all this as “*maltreatment*” or “*incorrect treatment*” and lose trust in the whole system of biomedicine.

Expressing understanding

– Aside from the doctor’s opinion about the therapy the patient has chosen or is thinking about choosing, listening to the patient’s narrative and expressing understanding is profoundly important.
– Especially in instances where the patient turns to CAM in desperation, they may develop marked emotional associations regarding CAM and identify the chosen modality or practitioner with hope in healing. In some cases, where the patient feels the doctor is “*judging*” or “*attacking*” CAM, they may feel like they themselves are being “*attacked*”. Consequently, if the physician condemns the CAM modality employed by the patient, the patient may in turn condemn the physician.

Possible consequences of loss of trust

Negative appraisal of conventional treatment

If the patient feels they were not sufficiently informed about their illness, treatment options, the elected treatment, or if they do not feel they have an opportunity to ask questions and speak freely, the patient may interpret somatic changes and bodily sensations arising in the course of conventional treatment as negative. A direct consequence of this is a negative appraisal of the effectiveness of the employed treatment.

No disclosure with the physician

The findings of the current study suggest that a patient may not disclose healthcare-related decisions to their physician in the following three areas: employing complementary therapies, discontinuing a conventional therapy, and arbitrarily modifying the conventional treatment. In the first area, complementary services/products and the conventional therapy may exhibit a harmful interaction and thus pose a threat to patient safety. Discontinuing a conventional treatment or modifying it (e.g.

taking less or more of a medication) may also be dangerous, provided these occur without communicating it to the attending physician.

Transfer of professional authority

Loss of trust in the doctor-patient relationship, a negative appraisal of the conventional treatment, and many other factors may lead to the patient, who is using a complementary therapy, placing their trust in the CAM practitioner only. This is not merely a matter of prestige; this influences the flow of information to a great extent. The patient will discuss all health-related issues (not just their current problem) with the practitioner they trust more.

Forgoing biomedical treatment

Patients can refuse a conventional treatment a priori (before even trying it) and a posteriori (after trying it, i.e. discontinuing treatment). In both instances, patients may justify their decision with the conventional treatment being “unnatural” or “non-selective”; these explanations are rooted in dispositions which may be addressed, provided the doctor knows of them or is willing to explore their underlying meaning.

Not receiving care

Forgoing biomedical treatment and severing contact with the physician might, in extreme cases, lead to the patient not knowing who they can turn to for help or not trusting any healer in any kind of medicine. The most dangerous outcome of decision-making processes and appraisal of experiences is when the patient loses trust in all medicines and practitioners, thus refuses help; this state is to be avoided at all costs.

Challenges of the future

Present findings show that it would be important to improve knowledge concerning CAM among biomedical professionals in order to enable adequate communication between doctor and patient regarding the use of non-conventional therapies. This does not mean they should advocate the use of CAM modalities, merely that it is crucial to be aware of potential harmful interactions or of potentially useful supplementary remedies. It would also be vital to promote sources of information where trustworthy materials on CAM could be accessed by patients who are considering using non-conventional modalities.

The candidate's publications related to the dissertation

2018 Zörgő, S., Olivás Hernández, O. Patient Journeys of Nonintegration in Hungary: A Qualitative Study of Possible Reasons for Considering Medical Modalities as Mutually Exclusive. *Integrative Cancer Therapies* 17(4):1270–1284.

2018 Zörgő, S., Purebl, G., Zana, Á. A Qualitative Study of Culturally Embedded Factors in Complementary and Alternative Medicine Use. *BMC Complementary and Alternative Medicine* (Jan. 22, 2018) 18:25.

2017 Zörgő, S. Pszichoszociális etiológia a hagyományos kínai orvoslást alkalmazók körében – A „lelki eredetű” testi betegség laikus oki teóriái. [Psychosocial etiology among users of Traditional Chinese Medicine – Lay theories of illness causation]. *Kultúra és közösség* 8(4):107-119.

2017 Zörgő, S. Szempontok a kvalitatív kutatás tervezéséhez és értékeléséhez. [Considerations for the design and evaluation of qualitative research]. *Lege Artis Medicinæ*, 27(10–12):418–426.

2016 Zörgő, S., Gyórfy Z. Gyógyítók a komplementer és alternatív medicináról – kvalitatív elemzés eredményei alapján. [Physician attitudes concerning complementary and alternative medicine]. *Lege Artis Medicinæ*, 26(9–10):421–428.

2016 Zörgő, S., Purebl, G., Zana, Á. A komplementer és alternatív medicina felé orientálódó terápiaválasztást meghatározó tényezők [Factors determining selection of treatment options oriented towards complementary and alternative medicine]. *Orvosi Hetilap*, 157(15), 584–592.

Publications independent of the dissertation

2019 Zörgő, S. and Peters, GY Epistemic Network Analysis for Semi-Structured Interviews and Other Continuous Narratives: Challenges and Insights. In: *Advances in Quantitative Ethnography. Communications in Computer and Information Science Series. Vol. 1112*. Eds. Eagan B., Misfeldt M., Siebert-Evenstone A., pp 267-277. Switzerland: Springer Nature.

2019 Zörgő, S. A Komplementer és Alternatív Medicina szociokulturális kontextusa. [The sociocultural context of Complementary and Alternative Medicine]. In: *Orvosi Szociológia [Medical Sociology]*. Eds. Z. Gyórfy, Z. Szántó, pp 113-128. Budapest: Semmelweis Kiadó.

2018 Zörgő, S. Pszichiátria vagy Alternatíva? A komplementer és alternatív medicina vonzereje. [Psychiatry or an Alternative? The pull of Complementary and Alternative Medicine]. *Lege Artis Medicinæ* 2018;28(1–2):61–66.

2018 Zörgő, S. Vélemények az alternatív medicináról – Reflexiók egy kutatás eredményeire. [Opinions concerning alternative medicine – Reflections on a study]. Mindennapi pszichológia XI.(5):63-67.

2018 Nyíró, J; Zörgő, S; Földesi, E; Hegedűs, K; Hauser, P. The Timing and Circumstances of the Implementation of Pediatric Palliative Care in Hungarian Pediatric Oncology. European Journal of Pediatrics. 2018; 177 (7).

2017 Nyíró J, Hauser P, Zörgő S, Hegedűs K. A kommunikáció nehézségei daganatos gyermekek szüleivel a palliatív ellátásra történő áttérés során. [Difficulties in communication with parents of pediatric cancer patients during the transition to palliative care]. Orvosi Hetilap, 158(30):1174–1180.

2017 Zörgő, S. Valóban tudni akarom? Test-bizonytalanság-érzet. [Do I really want to know? The feeling of uncertainty in matters of healthcare]. Mindennapi pszichológia X.(5):19-22.2016 Zörgő, S. Ép testben ép lélek”? Vagy fordítva? [„A sound mind in a sound body?” Or the other way around?] Mindennapi pszichológia, VIII.(6):47-50.

Presentations relating to the dissertation

2019 25th World Congress on Psychosomatic Medicine (Florence, Italy). “Semiotic Network Analysis: modelling patient cognition and behavior vis-à-vis therapy choice” (S Zörgő, GJY Peters)

2018 31st Conference of the European Health Psychology Society (Galway, Ireland, UK). “The ‘natural’ as embodied metaphor – and its role in therapy choice and self-regulation”

2018 UCSD-UCLA Graduate Student Conference on Culture, Health, and Mind (San Diego, UCSD, USA). “‘Energy economics’ – concepts of energy and their interaction with therapy choice in Hungary”

2017 Anthropology Matters!, the 116th Annual Meeting of the American Anthropological Association (Washington, DC., USA). “Bodily sensations within the context of alternative medicine – Embodied perception in the therapeutic process”

2017 Annual conference of the Hungarian Psychiatric Association (Siófok). “Cultural dispositions and their effect on therapy choice”

2016 30th Conference of the EHPS/DHP Behaviour Change: Making an impact on health and health services (Aberdeen, Scotland, UK). “The psychosocial context of bodily sensations – Embodied perception in the setting of alternative medicine”

2016 Annual conference of the Hungarian Psychological Association (Budapest). “The construction of psychosocial etiologies based on patient narratives of Traditional Chinese Medicine”

2015 World Congress on Psychosomatic Medicine (Glasgow, Scotland, UK). “The cultural construction of illness symbolism – Based on a medical anthropological analysis of interacting biomedical and alternative explanatory models of illness among patients and practitioners”