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Rurality, mobility, identity: Women's use of complementary and alternative medicine in rural Australia

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ABSTRACT

This article explores why women in rural and remote areas of Australia use complementary and alternative medicine (CAM) at higher rates than their counterparts in urban areas. Drawing on qualitative interviews with 60 women 60–65 years of age, currently living in rural Australia, we explore the possibility that CAM use in rural areas may be embedded in processes of spatialised identity-building and the health-creating practices of mobile, ex-urban, individuals who drive this process. We problematise previous explanations which suggest CAM use in rural areas is principally derived from a lack of biomedical service provision and enhanced community ties showing instead how and why identity and mobility are useful additional variables for understanding CAM use in rural areas.

1. Introduction

Previous research has found significant differences in urban and rural women's use of complementary and alternative medicine (CAM), both in Australia (Adams et al., 2003a, 2011; Wardle et al., 2012) and internationally (Herron and Glaser, 2003; Leipert et al., 2008; Lind et al., 2009; Nunes and Esteves, 2006). Within Australia, Adams et al. (2003a) noted that increased use of CAM in rural areas was statistically associated with poorer access to conventional medical care and a greater sense of community amongst rural residents. International studies have shown similar spatial stratification in CAM use (e.g. Herron and Glaser, 2003; Leipert et al., 2008; Lind et al., 2009; Nunes and Esteves, 2006). Such patterns have been linked with limited access to conventional health care services in rural areas (Brown et al., 1999a; Young et al., 2000), closer working relationships between GPs and CAM providers in rural areas (Herron and Glaser, 2003) and lower levels of satisfaction with GPs in geographically isolated areas (Young et al., 1998). Yet, the need to better explain spatial differences in CAM consumption has been repeatedly acknowledged (Adams, 2004; Adams et al., 2003b).

Aforementioned explanations given for increased CAM use in rural areas may be understood in terms of two drivers. First, is the 'deficit driver' (Bourke et al., 2010), a hypothesis postulating that people seek alternative forms of treatment as a result of various shortcomings associated with biomedical service delivery. The second, which we term the 'community driver', postulates that rural places foster a more collaborative and integrative sociality. These two explanations have distinct normative values and policy implications. The deficit driver indicates that CAM use is embedded in broader issues within biomedical healthcare provision and governance in rural regions of Australia. In contrast, a perspective that CAM use is tied to community/sociality suggests distinctive, complex integrative rural networks, functioning separately from the politics of healthcare delivery and the role of the modern state, are at play. Factors derived from geographic isolation in a large continent such as Australia almost certainly create cogent disadvantage (deficit) in terms of emergency care and diagnosis and treatment facilities that are dependent on specialised, hi-tech equipment (Bourke et al., 2010, 2012). However, as a stereotype, the 'deficit' model of rural and remote healthcare behaviours risks neglecting the heterogeneous and dynamic character of rural places, the agency of rural inhabitants and innovations that take place therein (Bourke et al., 2010).

In this paper we foreground identity and mobility as important drivers of women's use of CAM in rural Australia. We describe

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how CAM operates as part of the mutually constitutive processes of identity construction and place making in the context of women's therapeutic pluralism and mobile healthcare practices.

1.1. Identity, mobility and CAM use in rural Australia

Identity processes impact to shift healthcare practices as drivers of individual and collective behaviour (Popay et al., 2003; Williams and Popay, 1999). That is, identity and community are entwined concepts that can enact medico-cultural transformations. Identity formation incorporates processes tied to emotion and an individual's sense of wellbeing and may be, furthermore, embedded in place making practices (Gesler, 1992; Popay et al., 2003). Through ongoing and active relationships between identity and place, one can develop a *sense of place* and belonging, senses that are associated with emotional states comparable to spiritually derived feelings of wellbeing (e.g. Gesler, 1992; King, 1996; Trigger and Mulcock, 2005). Such feelings can assist healing (e.g. Doster et al., 2001; Groleau et al., 2010) and may be aspirational; that is, the search for a feeling of belonging and emplacement may mobilise individuals and impact on therapeutic landscapes.

In the case of observed elevated CAM use among women in rural areas of Australia (Adams et al., 2003a, 2011; Wardle et al., 2012), mobility and the formation of particular spatialised identities may be shaping healthcare practices in a rather interesting way. In recent times, the 'tree-change' (and/or 'sea-change') phenomenon (Costello, 2007) and other forms of counter-urban migration (Boyle and Halfacree, 1998; Halfacree, 1994) have accelerated to introduce new spatialised (rural) identities in, and that have transformed, some parts of rural Australia. Evidence suggests that these new identities may be inflecting change through the increased availability and use of CAM in rural areas (Robinson and Chesters, 2008). There may be an important symbolic dimension linking this mobility with CAM use and geographers have postulated that CAM may provide a symbolic vehicle for the construction of situated identities (Andrews, 2003; Andrews et al., 2004, 2012; Wiles and Rosenberg, 2001). While the likely role of CAM in identity formation and place-making has been acknowledged (e.g. Andrews et al., 2012; Wiles and Rosenberg, 2001), it has received little empirical attention to date (Andrews et al., 2012). Anthropological analyses of identity and place support the possibility that CAM could play such a role. In Australia, analyses show how identification with one's 'natural' environment, such as particular plants and animals of particular geographic origin (either 'native' to Australia or from elsewhere), provide a means by which settler-descendants may form and maintain attachments to place and achieve a sense of wellbeing that derives from belonging (e.g. Franklin, 2006; Mulcock and Trigger, 2008). These analyses provide empirical evidence that specific attributes of nature, as markers of place, can assist to situate identities. Because of its emphasis on consuming 'natural' substances as well as the way in which its geographical origins are readily identifiable (e.g. as it explicitly includes elements 'Chinese' or 'Ayurvedic' traditions), it is quite plausible that the consumption of CAM offers similar symbolic 'materials' by which mobile, and thus potentially rootless, identities may be grounded. It is the plausibility of such ideas that we interrogate here.

2. Methodology

2.1. Sample

Following ethical clearance by the authors' universities, we completed semi-structured interviews with 60 women who participated in a CAM survey-based sub-study of the Australian Longitudinal Study on Women's Health (ALSWH). ALSWH began in 1996 and includes women in three age groups, randomly selected from the national Medicare database and invited by mail to participate. The focus of this study is women from the 1946–1951 cohort, aged between 45–50 when the study commenced in 1996 (60–65 at the time of interview). At survey one, 14,779 mid-aged women consented to participate and they are representative of the national population of women in this age group (for details see Brown et al., 1999b). For the CAM sub-study, 2120 mid-aged women who had indicated in survey five (2007) that they consulted a CAM practitioner in the last 12 months were mailed a questionnaire. Of these women, 1800 (85%) returned completed questionnaires and 80% of those offered to complete a follow-up qualitative phone interview. The women interviewed for this study were drawn randomly from those who consented to be contacted for a qualitative interview; they comprise a sub-sample of the group of women on which we have reported statistically significant urban–rural variation in CAM use (Adams et al., 2011). We used a stratified random sampling strategy to select interviewees who, as self-reported, were on the spectrum from high to low users of CAM practices and practitioners. Our sample was also stratified according to participants' location of residence, classified according to a four part scale of urban (1) and rural (regional: 2–3 and remote: 4) locations. Of our sample of 60, 17 women interviewed resided in urban areas and 43 resided in rural areas.

2.2. Interviews

Given the national distribution of the sample, phone interviews were the most feasible and effective option for obtaining good quality data. We took a biographical approach to interviewing – where CAM use was discussed within the context of a woman's health history – and this accommodated the development of good rapport with each interview lasting approximately 1 h. Neal and Walters (2006) have shown how interviews conducted in/of rural settings are politicised events and can, in certain circumstances, elicit idealised discourses of the rural. It is possible that the method of telephone interviewing, which eliminates contextual data and non-verbal cues from the interviewer's purview, could enhance such a 'bias' towards eliciting positive and/or idyllic accounts because of the interviewer's inability to adequately assess participants' accounts. While this is a potential limitation of our interviewing approach, it is our sense that the method of telephone interviewing was highly successful in obtaining a candid depiction of women's viewpoints regarding their health and wellbeing. In fact, telephone interviewing appeared to have a kind of 'confessional' effect with many women speaking, in both positive and negative ways, about a variety of sensitive issues including their current state of mind, past and present relationships, traumatic experiences with healthcare practitioners and issues relating to their sexual health and function. In a few exceptional circumstances, women's willingness to talk meant that interviews lasted almost 2 h.

2.3. Analysis

The methodology for this project sits within the interpretive traditions in sociology. Although our sample comprised women, our intent was not to focus solely on the gendered dimensions of CAM-use (however, for such analysis see Meurk et al., in press). Although women's health practices maintain important gender specific elements, women's roles as healthcare providers within the home mean they are also powerful in shaping broader (dominant) health practices. The aim of analysis was to understand and represent the varying positions adhered to regarding