Looking for the water from a deeper well: an investigation into spirituality and natural medicine education

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Looking for the water from a deeper well

An investigation into spirituality and natural medicine education

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Declaration

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the University’s rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the University (as they may be from time to time.)

Airdre Grant

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Abstract

This investigation addresses the importance attached to spirituality within the culture and curriculum of a select group of naturopathy training programs in Australia. The investigation is premised on a view that spirituality is foundational to the practice of naturopathy, which has as its inspiration a belief that an integrated balance between body, mind and spirit is essential to the attainment and maintenance of good health. This holistic view of health is not particular to natural medicine generally, but the practice of naturopathy relies heavily on this view for its uniqueness.

Naturopathy has a lineage dating back to the ancient Greeks. Over recent centuries, however, health care practice in the West has become dominated by biomedicine, which does not require any assumptions about the importance of the balance between mind, body and spirit. The dominance of biomedicine has placed naturopathy at the fringe of health care practice. Over recent years, however, certainly in Australia, resurgence in the demand for naturopathic medicine is evident. As a consequence, there has been an educational demand to train more naturopaths. It has also been accepted that the higher education system should provide this training.

The question that underpins this present investigation is whether, in the recent expansion of naturopathy training programs, the profession’s distinctive commitment to a holistic view of health, and especially to the importance of a spiritual dimension, is being preserved? The thesis also addressed questions about the culture of naturopathy training programs in Australian higher education institutions, and about the impact, if any, on that culture of the recent growth in popularity of evidence-based approaches to health care practice.

The investigative methodology adopted is that of naturalistic enquiry, which relies largely on the inductive analysis of insights provided by key informants, supplemented in this investigation by documentary analysis and site observations. Two training programs, one at a university and the other at a large private college, were the main sources of informants for the investigation – though four other private colleges were also selected as sites of interest.
Individual and focus group interviews were conducted with participating lecturers and students.

The investigation concludes that, though there is widespread acceptance across the training programs examined of the fundamental philosophical importance to naturopathy of spirituality, the topic is neither consistently nor intensively addressed in the curriculum, except perhaps in the teaching of homeopathy. In the secular culture of Australian higher education, spirituality is a difficult concept to discuss. Its importance is also being pushed into the background by the increased value being placed on scientific knowledge. The consequences of these circumstances for the future identity and integrity of the profession of naturopathy are far-reaching.
List of publications


Conferences

Posters

2\textsuperscript{nd} Australian Conference on Spirituality and Health 27–29 August, 2007, Adelaide, South Australia

Third International Congress of Complementary Medicine and Research (ICCMR) 29–30 March, 2008 Sydney, New South Wales Australia

Presentations

National Herbalists Association of Australia (NHAA) International Conference
March 19–21, 2004, Canberra, ACT Australia. Presentation topic: Spirituality and health

Dedication

For my mother, Rosemary Grant, 1920–1971
Acknowledgements

It began with a dream. In the middle of a sad, dark year of feeling completely lost I had a vivid dream. A dream that was so strong that it woke me up with the firm instruction ringing in my head that I should do a PhD on spirituality and health. The directive was so powerful it felt like a message from the Divine. For once I listened and obeyed and set out on a path that has led to this. Of course I had no idea that it would be such a long, hard path and what I would learn along the way about endurance, perseverance and tenacity as well as self-doubt, despair and self-pity. It’s been a struggle and it’s been a blessing. None of it has been easy and a lot of it has rewarded me with a deeper understanding of spirituality and health as well as my own capacity to endure, to research and to write.

I couldn’t have done it without help from the lecturers and friends who walked alongside me on this journey. Professor Martin Hayden was a superb supervisor and guide. His immense patience and deft intelligence provided me with invaluable support as I lurched and stumbled along the path. Dr. Joan O’Connor gave generously of her wisdom and expertise helping in matters practical as well as pulling me out of the PhD doldrums on more than one occasion. Professor Stephen Myers was the one who placed me firmly on the path, supporting me with his mixture of faith, intelligence and stout loyalty. Sue Evans, Rosalba Courtney and Holly Davis cheered me on. Of course any work I did is built on the shoulders of those who have gone before. I thank the lecturers, friends and colleagues who are around me or who I read and consulted for their help, inspiration and guidance. In particular Cathy Avila was my companion on this long journey; we helped each other as we came unstuck on numerous occasions. Rhonda Ellis was a patient and exasperatingly thorough proofreader whose attention to detail was greatly appreciated. Annie Abegg polished the document for me so it could shine. My dear colleague Louise Horstmanshof taught me the finer details of Endnote. The title of the thesis was inspired by the song, Deeper Well, written by David Olney and sung by Emmylou Harris on the album Wrecking Ball. My country, New Zealand, and my family, my father Alister, sister Leith, big brother Malcolm and my twin brother Angus are deep in my heart.
My family provided me with love and laughter and put up with a lot. Finally I will have a weekend where I can play with them instead of sitting on the computer muttering foul curses. Rosie and Hanne and Chris all make me feel happier and I am deeply grateful that they are in my life. I thank them for persevering with me.
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Chapter 1

Introduction

The investigation addresses the role and importance of spirituality in the training of naturopaths in Australia. Spirituality is a foundational concept for the practice of naturopathy, yet its importance over recent years within naturopathy training programs appears to be declining. The increase in popularity of evidence-based approaches to health care provision has been a particular source of challenge. So too is the fact that the naturopathic profession, certainly within Australia, has never been especially successful in articulating and enforcing an agreed-upon set of professional expectations for programs leading to a qualification for practice as a naturopath. Against this background, an in-depth investigation of the status of spirituality in the training of naturopaths in Australia appeared to be timely. This chapter introduces the investigation.

Research problem and its significance

This research addresses the ways in which spirituality is experienced as being embedded in the culture of naturopathy training programs in Australia. Important terms here include naturopathy, spirituality and culture.

*Naturopathy* is a significant branch of natural medicine and a long-established field of health care practice. It has its roots in traditional wisdoms about healing based on the power of nature that can be traced back to Hippocratic philosophy in ancient Greece. Consistent with its lineage, it attaches value to the health and healing capacities of nature – including sunshine, fresh air, unprocessed foods and medicines that are derived from plants and minerals. Its treatment protocols are largely non-invasive and are deemed to be holistic in that their focus is the ‘whole person’, rather than simply a body part or body system and a set of presenting symptoms. Naturopathy is a designated area of professional health care practice within many national health care systems, notably in the USA. As such, it is generally required to subscribe to national requirements for professional recognition, including
requirements related to the training of entrants to the profession. In Australia, however, though the profession is institutionally recognized in a variety of ways, including for the purposes of obtaining private health insurance, it is not yet registered under statute as having a specific legal identity. As a consequence, admission to the profession is not regulated and there is no regulated statement of professional expectations regarding the basic knowledge, skills and attitudes required for practice as a professional naturopath. Chapter 2 addresses the institutional context of the practice of naturopathy in Australia.

*Spirituality* is a complex concept, with many dimensions, some of which are exclusively religious. In the context of this investigation, spirituality refers to a state of mind that is accepting of the everyday importance of transcendence in giving meaning to life. This transcendence refers to a sense of connection with a source or higher power that exists outside of the self and apart from the cares and concerns of daily life. This state of mind is intrinsic to naturopathic medicine because the practice of naturopathy is based on acceptance of a belief in the importance to health of the wellbeing of the whole person, embracing mind, body and spirit and that all these components have influence on health. Respect for this wholeness is integral to the professional practice of naturopathy. Chapter 2 addresses the nature of spirituality in the context of naturopathy.

*Culture*, which is also a complex concept, concerns the beliefs, values and attitudes together with the usual codes of communication and accepted forms of behaviour that define a social group (Brown, 1953; Swidler, 1986). Becoming part of a culture entails a process of enculturation, which has both overt and tacit dimensions. The overt dimension includes many formally prescribed rites of passage – in the case of naturopathy these generally include the successful completion of tests of theoretical, practical and clinical competency. The tacit dimension relates more to the unwritten rules, the accumulated wisdoms and the taken-for-granted ways of doing things that, though learnt informally, are fundamental to being accepted into the social group – in the case of naturopathy, these would include an ability to accept, to articulate and to explore the practical implications of a belief in the wholeness of mind, body and spirit in contributing to the health of an individual. Chapter 4 addresses the cultural dimension of naturopathy education in greater detail.

Three specific questions underpin this investigation. The first question is: *what are the distinctive features of the culture of training programs in naturopathy across a range of*
Australian higher education institutions? The question is important because of its contextual relevance to an understanding of the importance attached specifically to spirituality within these programs. The question is prompted also by the fact that, over recent years, many new types of training programs in naturopathy have been developed in Australia. It is not known to what extent they each share a common cultural identity.

The second question is: within the culture of naturopathy training programs in Australia, is there a common commitment to the role and importance of the spirit, as a constituent element in the mind/body/spirit approach to healing? The question is important due to spirituality being foundational to the practice of naturopathy. If novices to the field are not grounded in its relevance and significance, then naturopathy risks losing a unique professional identity (Tovey, Easthope, & Adams, 2004).

The third question is: what has been the effect, if any, of evidence-based approaches to health care practice on the culture of training programs in naturopathy? Evidence-based approaches to health care practice are now widely influential. These approaches have a clear and obvious appeal because of their potential to increase the probability of success of therapeutic interventions. In the context of naturopathy, however, they are difficult to implement because defining operationally the precise nature of naturopathic treatments is sometimes impossible, given that these treatments are highly individual and have their focus on the whole person (embracing mind, body and spirit). Naturopaths are, however, under increasing pressure to be mindful of the need for evidence-based approaches to the provision of health care practice. The effect of this pressure on the culture of contemporary training programs in naturopathy, though discernible by all, has not been well documented.

Research setting

The past two decades have seen remarkable changes in the field of natural medicine in Australia. As has happened internationally (Cohen, 2002), there has been a huge resurgence of public interest in the field. Indeed, it is estimated that as many as one-quarter of all Australians now make use of some form of natural medicine on a regular basis (MacLennan, Wilson, & Taylor, 1996, 2002). The growth of interest has brought with it a growth in demand for training programs. It has also brought to the surface yet again long-standing questions about the ‘scientific basis’ for many therapeutic practices in natural medicine.
Concerns about the need to ‘protect the public’ from unqualified or poorly trained practitioners have been widely expressed over recent years.

Naturopathy is a particular modality within natural medicine. It is also one of the better-established modalities in Australia, and, at least in recent years, it is one of the better-respected modalities. Respect for naturopathy appears to have been positively influenced by the fact that most new entrants to the profession now undertake tertiary education programs. In Australia, universities and private colleges, often working in partnership, provide these programs. This training model represents a major departure from a more traditional apprenticeship-based model of training, and it has brought with it a far greater emphasis on the need for students to acquire a broad base of biomedical sciences and an understanding of the science underpinning naturopathic treatments, such as basic knowledge about the ways in which herbal remedies affect bodily processes. Students have also become increasingly exposed to the importance of an evidence-based paradigm for health care practice.

Respect for naturopathy appears to have been additionally influenced by the extent to which the profession has adopted an image of being more scientific. The transition is a difficult one, however, because, at its core, naturopathy is based upon a philosophy that true and ongoing health resides in achieving an integrated balance of mind/body/spirit, hence requiring attention to the whole person (Fulder, 1996; Griggs, 1981). Treatment based on this philosophy is not readily amenable to evidence-based review. As a consequence, there is concern about the extent to which naturopathy, as traditionally practised, can sustain an image of being more scientific. At the same time, however, there is mounting evidence that patients increasingly want more from a patient/practitioner relationship than simply a science-based account of what needs to be done in order to restore health (Koenig, 2003; MacLennan, Myers, & Taylor, 2006).

Research approach

The research involves an exploration of the culture of naturopathy training in a natural setting where this type of training is provided. It employs interviews, observations and documentary analysis in order to build a comprehensive understanding of both the overt and the tacit dimensions of this culture. Consistent with the procedure of naturalistic enquiry, sites for the investigation were selected on the basis of their likelihood of providing an insightful understanding of what is involved in the training of naturopaths. A process of inductive data analysis was employed for the purposes of ‘making sense’ of the data through the development of emergent themes (Lincoln & Guba, 1985 p.202). Chapter 5 provides more details about the methodology.

Scope of the investigation

The investigation is confined to Australia. Training programs for naturopaths in Australia are extremely varied, reflecting the fact that the profession is not regulated by means of a statutory set of requirements. Chapter 2 provides further detail about this context. Knowledge about the extent to which the profession’s situation in Australia differs from its situation in other jurisdictions is not well documented, and this topic, though addressed for the purposes of reviewing the relevant literature, has not been systematically explored in this investigation.

The investigation is also limited to documenting the experiences of students and lecturing staff with a small number of training programs in Australia. In the context of qualitative research, this characteristic is not necessarily a limitation because what matters is the richness of the data collected, rather than its representativeness. All the same, it would have been desirable to have included in the investigation the consideration of a wider range of training programs. For reasons reported in Chapter 6, however, political sensitivities presented a barrier in this regard.

Organisation of chapters

Chapter 1 has sought to introduce the investigation. Its purpose has been to provide an orientation to the key research questions, the research setting, the research approach and the scope of the investigation.
Chapter 2 locates current arrangements for the training of naturopaths in Australia within an historical setting. It also reviews the range of contemporary challenges facing naturopathy training in Australia.

Chapter 3 provides an account of the historical and conceptual foundations of natural medicine and hence of naturopathy. It discusses the nature of the challenge presented to naturopathy by the recent increase in the importance attached to an evidence-based approach to health care practices.

Chapter 4 considers specifically the centrality of the concept of spirituality in natural medicine and it addresses the implications of the importance of this concept for the training of naturopaths.

Chapter 5 presents details of the design and method of the empirical investigation. It addresses particularly the nature of qualitative enquiry, details of the sites for the investigation, the ways in which relevant documentary and interview data were collected and analysed, the importance of considerations related to trustworthiness and reliability and the format for reporting the data in the three chapters that follow.

Chapter 6 reports on how the relevant documentary material was evaluated in terms of the quality of attention given to the role and importance of spirituality as a foundation for the practice of naturopathy. The chapter also identifies key emergent themes relating to the context within which naturopathy students and their teachers engage with spirituality.

Chapter 7 presents an account of the experiences of students undertaking naturopathy training at three sites, one of which was a university and two of which were private colleges. A total of fourteen students were interviewed individually for the purposes of obtaining an in-depth understanding of their engagement with spirituality in the curriculum. Two focus-group interview meetings, involving a total of seventeen students, were also held. In reporting on student experiences, details of information obtained from lecture and tutorial observations, as well as from prospectuses, unit outlines and course outlines, are also reported where appropriate.
Chapter 8 presents an account of the results of in-depth interviews with a total of thirteen lecturers and each was interviewed individually. Seven of the lecturers were from a university and the others were from a private college. Four of the lecturers were primarily clinicians thereby providing insights about the ways in which spirituality is an element not only in classroom settings but also in clinical settings.

Chapter 9 draws together the main insights from the investigation and it presents a discussion of their implications. It seeks particularly to provide a synthesis of the findings from multiple sources, and it draws the reporting of the investigation to a close by returning to the three key research questions introduced earlier in this first chapter.
Chapter 2

Naturopathy training in Australia

Ever since the early days when Australia was a collection of British colonies, naturopathy has been an element in health care provision.¹ Formal training programs in naturopathy are, however, a relatively recent phenomenon. Traditionally, new practitioners acquired their skills and knowledge by means of an informal apprenticeship with a recognised practitioner. This approach gave way to the establishment of specialised schools. More recently, naturopathy training has made an entrance to the higher education system. As will be reported in this chapter, however, its foothold in higher education is not firm and its place as a recognised form of higher education continues to be contested. The chapter locates current arrangements for the training of naturopaths in Australia within an historical setting. It also reviews a range of contemporary challenges facing naturopathy training in Australia.

Historical context

Contemporary naturopathic practice in Australia has its roots in the philosophy and practices of the nature-cure movement that developed during the mid-nineteenth century in the Austro-Hungarian region of Europe (Lin, et al., 2006). The movement advanced a philosophy of ‘returning to nature for health’ and it looked to the agents of sunshine, fresh air and water and leading a morally sound life as being fundamental to the maintenance of good health. The movement also endorsed treatment techniques such as bleeding, blistering and purging, though these practices could often be as dangerous to health as the illnesses they were meant to remedy.

These health care practices were all in evidence on the goldfields of Victoria and New South Wales during the 1850s and 1860s, when there was an explosion of immigrants to these colonies from all over the world. A sizeable proportion of the immigrants were from China.

¹ Australia did not become a Federation until 1901. Up until then, it was a collection of relatively independent British colonies.
and they brought with them the practices of traditional Chinese medicine (TCM). Also present were herbalists, homeopaths and hydropaths (Evans, 2000).

From the 1880s through until the 1920s, influences from England and the United States were more strongly felt. Though details are sketchy, it is evident that during this period homoeopathic and herbalist traditions became more strongly entrenched (Martyr, 2002). In the 1920s, for example, a National Herbalists’ Association of Australia was established, which still operates today. The number of naturopathic practitioners in Australia at this time, though not formally recorded, was small. The period also saw natural medicine eclipsed entirely by biomedicine as the officially recognised form of primary health care provision, with practitioners of natural medicine relegated to the status of ‘quacks’.

The profession entered a new phase during the 1940s. Baer describes the period from 1940 to 1960 as being a period of ‘emergence’ (Baer, 2006b). A distinctive feature of the period was the emergence of leadership provided by a number of charismatic individuals. One of these individuals was Frank Roberts, who trained at the London School of Natural Therapies, established himself as a naturopath and teacher in Australia in 1929 and subsequently established a Health Academy in 1959. The Academy later became the Chiropractic and Osteopathy College of Australia. Another was Maurice Blackmore, who trained at the British Naturopathic College, came to Australia in 1923 and opened the first health food store in Australia in 1934. Blackmore’s company became extremely successful, providing him with a strong base for leadership in the profession. Yet another important figure from the period was Alf Jacka, who, during the 1960s, conducted the first recorded naturopathy course in Australia – a course offered on behalf of the British and Australian Institute of Naturopathy (Jacka, 1988).

During this period of ‘emergence’, however, the relationship between the naturopathic profession and the by now well-established field of biomedicine deteriorated. Adherents of natural medicine felt besieged by the lack of acceptance and poor press that attached to their professional practices. A culture developed whereby the profession became defensive but at the same time fervent, even to the point of being evangelical (Evans, 2000). Training institutions would issue qualifications but their value was questionable because the profession

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2 The British royal family have used homoeopathy as a healing tool for generations, promoting acceptance in that country.

3 Untrained persons who pretend to be able to provide health care services.
was not officially recognised. These institutions were unsupervised and those undertaking a training program in natural medicine did so because of a personal, and often passionate, commitment to the field.

The setting changed during the 1960s and into the 1970s. During this period there was a revitalisation of interest in alternative methods of healing. Natural medicine was rediscovered at the same time as enthusiasm among young people for the discovery of alternate lifestyles grew. In a context of stiffening resistance to the war in Vietnam, orthodoxies of all kinds were challenged, including in the field of health care practices. The demand for naturopathic services began to increase. Natural medicine went from being in the domain of the eccentric and the offbeat to having status as a legitimate and interesting alternative form of health care practice. Demand for training in natural medicine began to lift. Jacka established the Southern School of Natural Therapies in Victoria in 1961. Other naturopathic colleges followed, in Sydney, Melbourne, Brisbane and Adelaide. Professional associations were formed and the field became revitalised (Baer, 2006b).

Relationships between the natural medicine community, which included homoeopaths, herbalists, chiropractors and osteopaths as well as naturopaths, and government authorities began, however, to deteriorate. In 1961, for example, the Royal Commission of Inquiry into Matters Relating to Natural Therapists (Guthrie, 1961), established by the State of Western Australia (WA), recommended that the four modalities of chiropractic, osteopathy, naturopathy and dietetics should be banned. In 1974, the Commonwealth Government Committee of Inquiry into Chiropractic, Osteopathy, Homoeopathy and Naturopathy, chaired by E.C. Webb, the Vice-Chancellor of Macquarie University in NSW, reported scathingly on the profession of naturopathy, including on the education of naturopaths. The committee questioned, for example, why naturopathic colleges were allowed to give certificates to practise when training standards in these colleges were so poor, even to the point of being dangerous. The closure of naturopathic colleges was recommended. In 1975 a Victorian Joint Select Committee into Osteopathy, Chiropractic and Naturopathy also raised questions about the quality of naturopathic education. It noted though, that there was some anecdotal evidence about the efficacy of naturopathic practices and it proposed registration as a way of regulating the expanding profession of naturopathy. While these inquiries could be seen as a justifiable concern about an unregistered profession that was gaining increasing social acceptance and popularity, it was also the case that there was an undercurrent of passionate resistance from
the established medical profession to the inroads being made by naturopathy, a perceived competitor. The established medical profession was determined to maintain its hegemony in the field of health care practice. Practitioners of natural medicine were labelled as misguided and wrong in their practice.

The first sign of a more positive official stance on the place of natural medicine in health care provision came in 1986 in the form of a report from the Parliament of Victoria’s Social Development Committee. The report noted objectively that many Australians were using natural medicine as a primary, rather than secondary, health care option. It expressed the need for a constructive policy response. Concerns identified by this report included the fact that the private colleges in natural medicine were operating outside the regulated education system, and that professional associations with important stewardship responsibilities in relation to the burgeoning profession were dominated by college principals and owners who had vested interests that rendered it impossible for them to be objective in making informed decisions about good educational practices (Lin, et al., 2006).

Enrolments in these colleges began to grow exponentially. Up until the 1980s enrolments at the private colleges, which were the institutions providing training in natural medicine, were mostly confined to the dedicated enthusiast. During the 1980s and into the 1990s, attitudes to the legitimacy of knowledge in natural medicine changed (Goldbeck-Wood, et al., 1996) and private colleges experienced a boom in demand from students for which they were largely unprepared (Evans, personal communication, 2009). Many young people came to see holistic medicine as a desirable and rewarding career path (Myers, personal communication, 2009). Private colleges began to register with state governments as tertiary education providers, thereby gaining access to public finding. By the mid-1990s, the scene was set for naturopathic education to be accepted within the higher education sector. The transition occurred in 1995, when Southern Cross University in northern NSW became the first university in Australia to offer a degree program in naturopathy.

Present setting

Naturopathic education is now relatively well established across nearly all states in Australia. Baer reports that ‘the Australian state has gone further than any other state in a developed society in terms of supporting public education in various other complementary medicine
systems’ (Baer, 2007, p.171). In 2003 for example, there were as many as forty-seven naturopathy and herbal medicine education providers in Australia offering a total of 104 graduate and postgraduate courses in natural medicine with an estimated graduation of 350 naturopaths annually (McCabe, 2008). There are many pathways to obtaining a naturopathy qualification. The three most common avenues are by means of diploma and advanced diploma studies at a private college, degree studies at a university or advanced diploma studies at a college followed by additional studies at a university.4

Diploma and advanced diploma programs are generally of two to three years in duration. The main providers of these programs are private colleges, though there are also programs available from publicly-funded Technical and Further Education (TAFE) colleges. Members of staff responsible for the delivery of these programs are responsible for developing the curriculum. The awards must comply with general design expectations prescribed by an Australian Qualifications Framework (AQF) but the framework does not address curriculum content. Private colleges must have their programs accredited by a Vocational Education and Training Board (VETAB).

Publicly funded universities provide degree-level programs. Only one university in Australia, Southern Cross University (SCU), offers a complete undergraduate program in naturopathy; the majority of students in natural medicine programs study at private colleges. The SCU program is of four years in duration. The members of staff responsible for delivering the program determine its curriculum and the University, which is self-accrediting, approves the curriculum and issues a degree in naturopathy to students who successfully complete the program. Other universities also award degrees in naturopathy but they do so by admitting students who have already completed an advanced diploma to a one-year or a two-year course of studies that builds on the students’ existing knowledge and extends their knowledge in areas of science, including anatomy, physiology, and nutrition. The University of Western Sydney (UWS) was also providing an undergraduate degree program for naturopathy, without any initial diploma. The program has now been discontinued. Formal articulation agreements between individual private colleges and individual universities are normal. An example here

4 Within the Australian Qualifications Framework, an advanced diploma award is a post-secondary qualification usually obtained following two or three years of full-time study, or equivalent part-time study, while an undergraduate degree is a post-secondary qualification usually obtained following either three or four years of full-time study, or equivalent part-time study. In natural medicine, an advanced diploma generally requires three years of full-time study (or equivalent part-time), and a bachelor’s degree generally requires three to five years of full-time study (or equivalent part-time).
is an agreement between Nature Care College and Charles Sturt University. Students undertake three years of naturopathy studies at Nature Care College and then proceed to Charles Sturt University where they complete their studies in anatomy and physiology, chemistry and biochemistry.

A naturopathic curriculum leading to the award of a degree typically includes herbalism (sometimes known as phytotherapy), nutrition, tactile therapies, anatomy, physiology, chemistry, biochemistry, symptomatology and pathology. In the case of diploma and advanced diploma awards, the curriculum may only focus on herbalism, nutrition and tactile therapies and it may also include elective studies in homeopathy, reflexology, aromatherapy and related topics. All award programs would include a foundational unit of studies in naturopathy. The unit would normally be expected to cover the history and philosophy of complementary medicine. Students would be introduced here to foundation concepts in naturopathy, which should then be reinforced in their other units of study.

Students undertaking accredited courses through private higher education providers or at a recognised university in Australia are eligible for financial assistance in the form of a Youth Allowance. They are also liable for the payment of fees. Students at private colleges pay upfront fees. Students undertaking university courses are also required to pay fees though these may be deferred through the Higher Education Loan Program (HELP) – a scheme whereby the student elects to not pay upfront fees for their studies and the Government retrieves the fee debt, plus interest, concurrent with study or later on through the income tax system.

Contemporary challenges

Naturopathic education in Australia faces a number of challenges. Some of these are legacies of the way the profession has developed over time. Others relate to the way in which the provision of courses is organised and regulated. Yet others relate to fundamental curriculum issues that derive from changing community expectations concerning the extent to which health care practices should be scientifically based.
Effect of legacies

The culture of education in natural medicine has developed in a complicated and uneven way as the profession has grown and moved towards greater social acceptance. Because natural medicine has a history of being regarded with suspicion and treated with some contempt by the medical profession, enthusiasts with a sense of pioneering passion have been largely responsible for the organisation and conduct of naturopathy training programs. Government support for training programs has been cautious and has only within the past twenty years become accepted, largely because of the growth in consumer interest in natural medicine. Adding to the difficulties, there has also been a great deal of infighting between different professional associations associated with natural medicine (Baer, 2008), which has stalled all attempts to achieve any form of professional registration. As a consequence, there are no national standards for naturopathy education, which in turn has resulted in considerable differences between different educational providers in terms of what they have selected to include (or exclude) in the curriculum for their programs. The following table (Evans, 2008) provides an overview process of developing naturopathy education that has had a chequered history since the early 1960s.

<table>
<thead>
<tr>
<th>Year</th>
<th>Level of regulation</th>
<th>Title of report</th>
<th>Major recommendations</th>
<th>Comments in relation to the present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>State – Western Australia</td>
<td>Report of Honorary Royal Commission into the provisions of the natural therapists bill (Guthrie, 1961)</td>
<td>Naturopathy should be banned (this did not occur)</td>
<td>Herbal medicine is included as a discipline of naturopathy</td>
</tr>
<tr>
<td>1975</td>
<td>State – Victoria</td>
<td>Report of Joint Select Committee into Osteopathy, Chiropractic and Naturopathy Committee (Ward, 1975)</td>
<td>Concern expressed re standard of education for natural therapists</td>
<td>Slightly more positive than the previous WA report</td>
</tr>
<tr>
<td>1985</td>
<td>Territory – Northern Territory</td>
<td>Allied and Professional Health Practitioners Act (1985)</td>
<td>Naturopaths registered in the Northern Territory. Registration was withdrawn in 1991</td>
<td>Members of the Australian Natural Therapists Association the only naturopaths accepted, members of other professional associations rejected</td>
</tr>
</tbody>
</table>
## Table 2.1: Report titles, major recommendations and comments

<table>
<thead>
<tr>
<th>Year</th>
<th>Level of regulation</th>
<th>Title of report</th>
<th>Major recommendations</th>
<th>Comments in relation to the present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>State – Victoria</td>
<td>Social Development Committee Inquiry into Alternative Medicine and the Health Food Industry (Dixon, 1986)</td>
<td>Concern expressed re standard of education for natural therapists</td>
<td>The widespread public use of natural medicine accepted for the first time</td>
</tr>
<tr>
<td>1989</td>
<td>Federal</td>
<td>Therapeutic Goods Act (1989)</td>
<td>Complementary medicines regulated as a therapeutic goods</td>
<td>Fundamental changes to the industry which supplies complementary medicines, increased regulatory demands on manufacturers</td>
</tr>
<tr>
<td>2006</td>
<td>State – Victoria</td>
<td>Latrobe University Report into the Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine (Lin et al., 2005)</td>
<td>Recommendation that naturopathy and Western herbal medicine be registered</td>
<td>Recommendations still to be acted on</td>
</tr>
</tbody>
</table>

The recent history of the profession has, in fact, been one characterised by a slow and sometimes very difficult process of gaining official recognition – which, of course, has had important implications for naturopathy education. A report concerning the practice and regulatory requirements of naturopathy and Western herbal medicine (Lin et al., 2005), noted that the field of natural medicine in Australia is characterised by a complicated mix of associations, training providers and accreditation bodies. The report notes accurately that, in effect, anyone could establish a business as a naturopath and the educational standards of some providers of training programs are of uncertain quality. Different professional associations within the broad field of natural medicine have different standards for recognition. Because they are not especially cooperative with one another, progress towards having one national set of standards has been impossible to achieve (Baer, 2007, p.176).

The consequences of the legacy are evident in existing patterns of educational provision. An advanced diploma in naturopathy at one private college may require three years of full-time study, while at another private college the same qualification may require only two years of full-time study. Some programs may require the study of homeopathy as part of the core curriculum, while others may include homeopathy as an elective only, or not at all. Some programs include iridology (diagnosis through examination of the iris) as a unit of study, while others do not. Regardless of whether they obtained their qualifications in the form of a
diploma, an advanced diploma or a degree, all graduates are able to present themselves equally to the public as a qualified naturopath. The difference in the levels of training level is not necessarily evident to members of the public when they present for a consultation with a qualified naturopath.

A further problem is that scholarship in the field is extremely underdeveloped. Only a small minority of practitioners have a degree-level qualification and only a very small proportion of those responsible for training programs in naturopathy have publications in the field. In 2003, for example, only eight (all university lecturers) out of the hundreds of lecturing staff employed by colleges and universities to teach naturopathy had published articles in peer-reviewed journals in the field of natural medicine.

Lack of sufficient regulation

A contemporary feature of the private college sector of naturopathy education is that it is not regulated as being ‘not for profit’. It has been estimated that as many as 80 per cent of all private colleges are ‘for profit’ (McCabe, 2008). The situation has given rise to a level of entrepreneurialism that stands in stark contrast to the tradition of naturopathy training being provided by passionate leaders in the field. Private colleges are bought and sold with increasing frequency; they are renamed for the purposes of achieving greater market share; they offer programs that will appeal to a mass market and they remove programs, or elements within programs, that are not ‘selling’; their training packages become ‘commercial in confidence’; their key managers are not necessarily trained in naturopathy; and they have also become embroiled in tax-minimisation schemes. These developments have certainly resulted in increased financial investment in the form of improved facilities and resources, but they have also resulted in standards being compromised and, because the focus is upon selling places in training programs, there is a growing concern that the field of naturopathy is progressively becoming flooded with recent graduates who may not be able to secure enough regular employment for the purposes of maintaining their professional skills.

More broadly, the field of naturopathy education, whether delivered through the private college sector or through publicly-funded universities and TAFE colleges, is not well regulated. Unlike the situation in other professional fields, including nursing and medicine, there are no protocols or standards for determining what should be included in a training
program in naturopathy. The number of clinical hours, for example, can vary markedly between different programs. There is also a possibility that the clinical experience hours in this regard are well below international standards. McCabe (2008) has observed that the number of clinic hours in naturopathy training programs in the United States can vary from between 1200 and 1500 hours, whereas in Australia the range appears to be from 200 to 800 hours.

The most significant educational implication of there being no requirement for professional registration of naturopathy in Australia is that there are no standard requirements of naturopathy training programs. The Australian context is different from that existing in some other developed countries, most notably the United States where the Council for Naturopathic Medical Education (CNME), founded in 1978, accredits naturopathy qualifications, which are obtained upon completion of a four-year postgraduate program. The agency is recognised by the United States Secretary of Education and it covers courses offered across the United States and Canada. Naturopaths from accredited training programs are licensed to practice in fourteen states and four provinces in the US and Canada, respectively. Graduates of CNME-accredited courses are eligible to call themselves Doctors of Naturopathic Medicine or a Doctor of Naturopathy. The issue of the professional registration of naturopaths, and hence the application of a common set of standards to naturopathy training programs, is a contentious matter in Australia. Some proponents of registration believe that it might enable naturopaths to access benefits under the national Medicare system\(^5\). Currently a visit to a naturopath, which may cost anywhere from A$60 upwards, is an out-of-pocket expense that is not refundable in part or in whole under Medicare. Others point out, however, that professional registration is no guarantee of recognition under Medicare – the professions of chiropractic and osteopathy have been registered for over twenty years but still do not attract Medicare rebates (Baer, 2006a).

The impression should not be given that there is a complete lack of regulation of naturopathy training programs in Australia. There are course framework requirements with which all naturopathy training providers must comply. In the case of the universities, these requirements are self-determined, though within a framework of quality assurance that is managed by the Australian Universities Quality Agency. Government accreditation of private

\(^5\) Medicare is the Government funded national health care plan that subsidises visits to designated registered health professionals such as doctors.
colleges changed the culture of training in natural medicine deeply. In the case of the colleges, approval as a Registered Training Organisation requires that lecturing staff must be appropriately qualified. The requirement has had a positive impact on many college programs. Previously, private-sector colleges had few requirements for their teachers to have experience or training in educational practices. Under requirements for registration as a Registered Training Organisation, members of lecturing staff are required to have at least a basic level of training in competency-based teaching. The training program introduces lecturers to principles of adult learning and methods of competency-based teaching. University lecturers are not required to undertake this training, but they have frequent exposure and ample opportunity to attend educational training sessions on matters such as student assessment, teaching methods and the utilisation of new technologies in support of student learning.

Changing community expectations

The typical naturopathic patient has changed in recent times. Whereas once these patients might have been a minority group devoted to the values of healthy nutrition and a natural lifestyle, now they are much more likely to be representative of the population at large. They are likely to be quite well educated about the relative benefits of natural medicine, and they are likely to be drawing selectively on both natural medicine and biomedicine to meet particular health care needs.

They are also much more likely to be able to investigate for themselves, using the Internet, the scientific basis for claims made about the therapeutic value of naturopathy treatments. This capacity has created a new set of pressures for the naturopathic practitioners, and it has had significant implications for the naturopathic curricula. Naturopathy students are increasingly being required to understand the scientific basis of naturopathy and there is also a growing need for them to become conversant with the paradigm of evidence-based medicine (EBM). Regulatory structures and legal requirements concerning the therapeutic administration of herbal and other kinds of natural extracts have reinforced this need.

These developments have given rise to a new challenge for training programs in naturopathy. As Di Stefano points out, the foundational philosophies of naturopathy incorporate concepts that might not always be acceptable within biomedicine, such as working with the inherent healing power of the patient (vitalism), nourishing mind, body and spirit, and looking beneath
symptoms to the multidimensional causes of disease (Di Stefano, 2006). While these concepts are essential to the integrity of a curriculum in naturopathy, concern is being voiced that the teaching of these concepts is being diluted on account of the increased pressure for naturopathy to be presented as having a more scientific basis (McCabe, 2008).

Approaches to the teaching of naturopathy are also under pressure to change. Morling (2000) has observed, for example, that a competency-based teaching approach, which suits the delivery of programs with a high threshold requirement for the attainment of outcomes defined in terms of blocks of knowledge and skills, is not well suited to programs in which there should also be a focus on personal development. He expresses concern about a trend in naturopathy training programs in the direction of a greater reliance on a competency-based approach: ‘teaching this way becomes a methodology for ensuring the delivering of training without consideration for the soul and spirit of traditional medicine’ (Morling, 2000 p.49). Crellin, drawing upon the Canadian experience, reports that practicum clinics are pushed to teach their students to be like biomedical practitioners, as a way of getting them ready to integrate with the wider system. Teaching students to be fully holistic and integrated in their approach is deemed both hard and complex (Crellin, 2006).

The implications are important. The challenge for those involved in the delivery of education to naturopaths is that of balancing the interests of all parties involved. The risk is that, because of the increasing pressure to engage with science in the naturopathy curriculum, naturopathy students are more likely to be trained within a curriculum framework and approach to teaching that runs counter to the traditions of holistic medicine. The challenge is to keep the balance between what is of enduring importance to naturopathy education and what is required to meet the needs of a more scientifically informed society.

The development of students’ ways of thinking is also critical. There is a need for the healer to develop a critical and enquiring mind, one that is open to ways of listening and attending to patients on all levels. How the development of these attributes can be fostered in a curriculum that is becoming more crowded with requirements for students to master scientific knowledge is a contemporary challenge of some importance.
Concluding remarks

This chapter has attempted to provide an orientation to naturopathy education in Australia. A focus on the historical dimension has been necessary because so many aspects of the contemporary state of naturopathy education in Australia have been influenced by the past, or at least should be seen against the backdrop of what has happened in the past.

Certain themes are evident, but in each there are contradictory elements. Firstly, naturopathic training programs have over recent years attained respectability by virtue of at last being included in the mainstream of higher education in Australia. At the same time, however, there is little consistency between them in terms of their commitment to a common curriculum and approach, and the extent of the inconsistencies is possibly increasing because of market-driven behaviour in the private-college sector. Secondly, community interest in natural medicine has possibly never been higher than at present and this presents naturopathy training programs with a great many opportunities for long-term steady growth. The increased community interest is bringing with it, however, a tendency to value more a scientific rather than a philosophic foundation for naturopathic knowledge. In the process, elements of naturopathy education that have been of enduring importance to its integrity, are under pressure of being crowded out by the pressure to instruct students about the scientific underpinnings of professional practice. Finally, it has to be concluded that naturopathy training programs in Australia are remarkably fragmented in the sense that they do not conform to any set of common standards beyond those imposed by national framework requirements for educational awards. The fact that there is no requirement for the professional registration of naturopaths no doubt contributes a great deal to the situation. The history of the development of the profession in Australia is also a relevant consideration, distinctive as it is for the extent to which individualists have played important roles, especially during the past fifty years, in pioneering different schools of professional practice. It is ironic, though, that a profession that shares a philosophy of holism has not been better able to bring all parts of its training programs for naturopaths under one national umbrella of educational standards, curriculum consistency and common teaching practices.
Chapter 3
Foundations of Naturopathy in natural medicine

I swear by Apollo the Physician and Asclepius and Hygeia and Panacea and all the gods and goddesses making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant.\(^6\)

Naturopathy has its roots in natural medicine. Indeed, it is a contemporary form of health care practice that gives direct expression to a tradition of medicine that dates back to the ancient Greeks. The other form of medicine, referred to in the thesis as biomedicine, also has its roots in natural medicine, but it took a different path during the seventeenth century, influenced in large part by Descartes’s (1596–1650) proposition regarding the dualism of mind and body. Biomedicine generally regards the body as being separate from the mind and it tends to treat the body as if separated into different parts. Natural medicine, in contrast, views the body as a whole, having regard to both state of mind and state of physical wellbeing, and it sees all parts of the body as being interconnected and as having to be treated as a whole. Biomedicine has become ascendant as the dominant contemporary paradigm in health care practice, and the benefits it has brought to humanity have been enormous. Natural medicine has not disappeared, however. Indeed, there has been a dramatic resurgence of interest in it. This chapter provides an account of the historical and conceptual foundations of natural medicine and hence of naturopathy. It considers specifically the centrality of the concept of spirituality in natural medicine, and it addresses the implications of the importance of the concept for the training of naturopaths.

\(^6\) The first few lines of the Hippocratic Oath.
Origins and legacies

The history of health care practice in the West is largely a history of natural medicine. Indeed, it was not until the seventeenth-century Cartesian conception of disease as having a purely physical meaning, separate from a person’s ego, that a new form of health care practice, biomedicine, began to develop. Since then, biomedicine and natural medicine have moved in separate directions. They do, however, share common traditional origins. A brief look at some of the ancient figures and movements that have influenced the development of modern health care practice shows how intertwined they are in their origins. It also shows the links between health and spirituality from a time when society in the West held more closely to an inclusive and a spiritual way of understanding health.

The roots of natural medicine stem from practices that were linked to respecting the power of nature and that looked to the natural environment for an understanding of the body and of the forces that influence health and disease. These practices may have involved watching the moon, following certain rituals, praying to unseen gods and goddesses, as well as looking at what plants grew at what time of the year and what animals ate to restore their health. This information and more was collected and accumulated as part of the historical development of the West. The village craft of the wise elder was an ancient tradition, while the use of plant extracts and tinctures to effect healing sits at the heart of modern herbalism (Griggs, 1981). Some of these practices persist. Indeed, according to the World Health Organisation (WHO), herbal medicines are still used in traditional and indigenous cultures by 65–80% of the world’s population (Siahpush, 1999) indicating a strong connection still exists between humans and the natural world when it comes to health care. The traditions that lie at the heart of natural medicine and current health care practices are part of an historic lineage.

A brief examination of the history of the healing relationship shows the links between the popular practice of medicine and historical principles that were inclusive of the whole person and which were severed with the rise of dualism. To begin, the ancient Greeks are a rich source of influence on contemporary health care practice. Their model of health care practice was that of natural medicine. In 400 BC, for example, when Asclepius was the Greek god of medicine, and when there were over 800 temples in his honour, effecting cure required purification at a temple, a process that entailed bathing, dressing in appropriate robes and being sent into the inner sanctum to sleep and dream. The process was called incubation. The priests would diagnose and prescribe medicines according to the information gathered from
the dreams described by the supplicants. A legacy of this period is that the rod of Asclepius, a serpent entwined around a staff, remains the symbol of Western medicine to this day. The daughters of Asclepius were Medetrina (goddess of longevity), Hygieia (goddess of disease prevention), Panacea (goddess of healing), Aceso (goddess of recovery), Iaso (goddess of recuperation) and Agleaea (goddess of natural beauty). Hygieia was especially worshipped – her message being that true health came from knowing how to live properly (hence the word hygiene).

Another significant influence was the ancient Greek, Dioscorides (c.40–c.90 AD), who wrote De Materia Medica, in which he described in detail the medicinal properties and actions of over 600 plants. The text became the standard pharmacopoeia of the time and its influence continues to be felt in contemporary naturopathic and herbal medicine.

But, of the ancient Greeks, it is Hippocrates (c.460–c.377 BC) who has had the most enduring impact on health care practice. He taught that wellbeing was created through restoring harmony and balance, respecting the body’s self-healing power and assessing health through knowledge of the humours. The humoral theory of health believed the body was composed of four humours: black bile, blood, yellow bile and phlegm. An imbalance in these humours was said to be the cause of illness. Too much black bile, for example, made a person melancholic; too much phlegm made a person phlegmatic; too much yellow bile made a person choleric; and too much blood made a person sanguine. Hippocrates’s philosophy of living in harmony with nature is congruent with modern natural medicine, even though Hippocrates is claimed as the father of modern biomedicine. Hippocratic practice, although individualised, was pragmatic, and its prescribed treatments focused on the humours as evidenced by vomit, spit and excreta.

A prominent Roman physician and philosopher of Greek origin, Galen (c. AD 129–200), took Hippocratic theory and developed it into a highly influential model of teaching about health. He was prolific, writing over 500 books. His writings on the body were highly influential and shaped the practice and theory of medicine for over 1,500 years, providing a structure for understanding health and disease.

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7 It is sometimes confused with the caduceus, which is two snakes entwined around a staff – the staff of Hermes, god of alchemy and commerce, among other things.
The Persian doctor Avicenna (980–1037) took Galen’s work into the Arab world, influencing practice up until the seventeenth century. Avicenna was also prolific and wrote many treatises, including the fourteen-volume *Canon of Medicine*, which was a standard medical text in Western medicine for five centuries.\(^8\)

The practice of medicine continued to change and grow as people developed theories and these gained popularity and influence in society. The English herbalist Nicholas Culpeper (1616–1654) utilised knowledge of astrology to understand plants, people and diseases. At the time of his practice, knowledge of planetary influences was considered central to health care and treatment. His work combined the humours, herbalism and astrology and it was hugely influential, especially in promoting the use of medicinal plants. Although influenced by Galen, he moved away from practices such as bloodletting, which had been very popular at the time.

The Renaissance physician and botanist Paracelsus (1439-1541) had influence in the development of medicine. Called the father of pharmacology, he stood at the crossroads of ancient and scientific medicine. In his practice he combined the tools of astrology and botany along with developing the use of chemicals and minerals in healthcare. His practices involved an understanding that illness could be caused by chemical imbalance, which could be remedied. From this began the development of modern chemical medicine.

The next major shift came with the French philosopher, Renée Descartes (1596–1650). His philosophical approach introduced the concept that mind and body were separate. The approach was called *dualism* and it enabled medicine to focus on the physical, without being confused by the notion of spirit or soul. This was a major shift in healing approach. It accelerated a separation of the spirit from most health care practice. Dualism set the foundation for biomedicine, the system of medicine based very largely on deduction that currently dominates health care practice in the West. Biomedicine separates the body into parts to be dealt with. It fosters symptom-based medicine (if it hurts, fix it), which is a different approach from natural medicine, which seeks to find the cause of illness by viewing the body in context and as a whole, hence the reference to natural medicine as holistic medicine. Dualism is still debated as a philosophical construct (Holden, 1991; Marcum, 2008; Palmer & von Bertalanffy, 2007). While the modern reductionist approach was precipitated

\(^8\) Avicenna is considered one of most famous scientists of Islam and is a national icon in modern Iran.
by the work of Descartes the tensions between vitalism and mechanism do have a long history. Prior to Hippocrates, the ancient Greek philosopher Parmenides considered the notion of what is truth. His philosophies had influence on Plato.

A German physician, Hahnemann (1755–1843), resisted the shift to dualism. Hahnemann created the system of medicine called homoeopathy. Based on a principle of *like cures like*, the model developed included traditional nature-cure remedies such as sunshine, fresh air, rest and hygiene (the importance of these had been forgotten because of the popularity at the time of bloodletting and more toxic cures). His theory of homoeopathy remains taught and practiced in the field of natural medicine. Homoeopathy rests on a principle that illness is an upset to the vital force residing with each of us. Accordingly, homoeopathy sits uneasily with the principles of biomedicine.

Dualism signaled the separation of medical philosophies into *mechanism* (also referred to as *reductionism*) and *vitalism* (Bradley, 1999). Reductionism meant adopting a viewpoint whereby a particular agent and particular symptoms were seen as being the cause of disruption to the normal and effective workings of the body. According to this viewpoint, the goal of health care practice was the removal of the relevant agent and disagreeable symptoms. Examples of this approach are widespread in contemporary (biomedical) health care practice: homeostasis (the organisation and equilibrium of the organism as maintained by the physiological processes of the body) is restored by addressing the agent of ill-health and its symptoms by means of surgery to the affected part of the body, emergency care or the use of antibiotic medicines. Rapid advances in surgery and drug therapy profoundly amplified the value of this method and contributed a great deal to its popularity. It is at this point that natural medicine began to separate from the modern practice of medicine, particularly as it rested on the philosophy of vitalism.

Vitalism rests on a belief in the body’s innate self-healing capacity and underpins a practice approach in natural medicine geared towards supporting the innate capacity and using, if possible, minimalistic intervention. There are other ancient and contrasting systems of thought in health care that exist today which have vitalistic principles at their heart. These include traditional Chinese medicine (TCM), which is based on the five element theory (fire, earth, metal, water and wood) for diagnosis and which considers *chi* as a determinant of health (Kaptchuk, 2000) and Indian Ayurvedic medicine, which operates on a tridosha system in
which health is a balance between three doṣha (*vata, pitta, kapha*).⁹ They have specific and conscious underlying philosophies that define them and they have gained some popularity in the West. These two models of healthcare have at their centre a seeking for balance and a method that is about allowing that restoration of balance to heal the body (Desai, 1989; H. Sharma, Chandola, Singh, & Basisht, 2007) However the current dominant model of biomedicine is based on dualism, not vitalism and while these health care systems are tolerated within the biomedical paradigm, they exist on the fringes of modern health care practice.

The shift in focus associated with the adoption of dualism resulted in profound changes in the way medicine was practiced – from *bedside medicine* to *clinical medicine* (also called hospital medicine) to *laboratory medicine* (Seale, Pattison, & Davey, 1985). Up until the mid-eighteenth century in Western cultures, treatment was provided at home, or in the village or community setting. The doctor came to the patient. This style of care was known as *bedside* medicine and it existed at a time when knowledge of health and healing lay within the community and within the family and was not the property of a select and removed professional group. The doctor or health care practitioner, such as a midwife or herbalist, would be able to see all aspects of a person's life and this knowledge would be encompassed in treatment as the person would be observed and treated in their social and familial context. Treatment would include astrological and cosmic influences along with humours. *Bedside* medicine was also influenced by the miasmic theory proposed by Hippocrates, whereby a miasm, or stain, caused by something like rotting food or stagnant water, might create illness. It coexisted with the contagion theory from the Old Testament. Miasmic theory and contagion theory were precursors to germ theory (Tomes, 1990).

The next phase of care was known as *clinical medicine*. Hospitals had been in place since the 1500s in England as places for the poor and incurables, those who could not be treated at home. Religious communities, such as monasteries, provided care and ran institutions such as leper sanctuaries. However, in the eighteenth century, hospitals assumed greater size and importance as places that served medical needs and were staffed by surgeons and physicians (Labisch, 2001). In hospitals, doctors were able to see large groups of people, discern patterns of sickness, test the efficacy of remedies and observe the human body more closely. Bodies

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⁹ Chi, also known as *qi*, and the doshas are described as a vital force that resides in the body, without which life does not exist. In this regard they are similar to vitalism.
were dissected at death, revealing a great deal of knowledge about the anatomy. The stethoscope and the thermometer and other technologies were developed. Medical books were produced, providing much more accurate insights into the physiological workings of the body. Teaching hospitals developed for training purposes. As the training became more formal, knowledge became more centralised and the clustering of illnesses and symptoms enabled the categorisation of disease to develop (Cruse, 1999). Systems for understanding illness and pathologies developed, along with the classification of sets of organs and body systems such as the cardiac, renal and gastrointestinal systems. These initial classifications form the basis of modern specialisations. At this stage, the person could be seen as the carrier of the disease, a shift away from bedside medicine and its antecedents where illness was seen as imbalance with the environment. As Seale has observed, ‘in bedside medicine the whole patient is an expression of the disease, in clinical medicine the patient is seen as distinct from the disease’ (Seale, et al., 1985p.33) This style of thinking fitted in with the concept of the body as a machine. Illness began to be seen as a breakdown in the machinery of the body.

Rapid advances in medical knowledge took clinical medicine further and began the extension into laboratory medicine. The concept was advanced as the Age of Enlightenment progressed during the eighteenth century. This was a time when thinkers moved away from ‘superstition’ and ‘emotionalism’ to reason and systematic thought. The style of medicine worked with the microscope and the technology of viewing tiny components, such as microbes, further reduced the body into constituent parts. Medicine focused on the cell and this development contributed to the ascendancy of germ theory.

The latest stage in the history of health care practice and theory is scientific medicine, characterised in this thesis as biomedicine, where technology and detachment dominate. This stage represents an apex in the recent history of the development of science-based medicine. It relies heavily on technology for diagnosis and further extends the distance between patient and practitioner.

This brief history shows how modern practice and natural medicine spring from the same roots. The rise of dualism and its current expression of scientific medicine speak to a change of practice approach. Schlitz reminds us that the current dominance of biomedicine is underpinned by the metaphysical assumptions of materialism, objectivism, reductionism and physical determinism (Schlitz, Amorok, & Micozzi, 2005). These constructs make
acknowledgement of any differing worldview limited and difficult as they confine understanding through the limited lens of science. The diminution of the recognition of the spiritual side of health is a consequence of this shift. In a secular and technological age (in the first world) spirituality (and religion) became marginalised in this model of health care and it is only in recent years that there has been a rise in interest (this is perhaps indicative of the cyclical and ever-changing nature of knowledge). The role of the practitioner is as multifaceted as it ever was. Chilton describes the modern doctor as scientist, personal friend, counsellor and secular priest (Chilton, 1998). The phrase ‘secular priest’ speaks to the intimacy of the healing relationship and also reminds us of the time when the divine aspect of healing was more overtly acknowledged. Campo points out that ‘curing and healing are not the same and it is possible to achieve the later without succeeding in the former’ (Campo, 2003p.27). This distinction is a reminder of a time when healing was considered an art as well as a science and is where the work of the naturopath is focused. The modern practice of naturopathy holds true to its roots by affirming the importance of vitalism, connection with nature and the holistic view of the body. These constructs are key to the philosophies of naturopathy that holds recognition of mind, body and spirit as having equal importance in health.

Contemporary developments

The history of natural medicine has been cyclical in that it has moved from social, political and economic strength to being regarded as an outcast profession, to gaining prominence and social acceptance in the latter half of the twentieth century (Eisenberg, et al., 1993; MacLennan, et al., 2002). In the West during the first half of the twentieth century, a variety of ‘natural’ health care practices existed and thrived, having survived and developed quietly alongside the rise of orthodox medicine. These practitioners were often called hygienists. The naturopath, a term coined in 1902 by a medical doctor, John Scheel, was used by the American, Alfred Lust, in 1905 when he opened the first school of naturopathy. By the 1930s, Lust reported he had 40,000 naturopaths as members of the American Naturopathic Association (founded in 1919) (Baer, 2001). The practices of naturopaths in those days included hydrotherapy (water cures – sweat, steam, baths and saunas).

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10 In Australia the Hydro Majestic Hotel in the Blue Mountains near Sydney, NSW, has been a reminder of a time when it was the health fashion to ‘take the waters’.
The hygienists and the practice of nature cure were at the heart of naturopathy as it began to coalesce as a profession as we know it today. The merits of a natural lifestyle included the importance of eliminating evil habits like the poisons of tea, coffee and alcohol. Often these early nature proponents were committed Christians and their philosophies included respect for God, as well as living wholesome lives. New ways of living that included fasting, exercise, sun baths, wholesome food, good posture and being close to nature were promoted (Lindlahr, 2004). Henry Lindlahr, a prominent American naturopath in the early 1900s, built a college and a sanitarium that promoted drugless healing and respect for the body’s own self-healing capacity – a basic naturopathic principle which is taught today. His work was popular and influential. When John Harvey Kellogg (who, with his brother, invented a well-known breakfast cereal – which was originally a health food) died in 1943, aged 91, there had been over 300,000 patients at the Battle Creek Sanitarium, a natural medicine institute he conducted along nature-cure and drugless therapy guidelines (Gerstner & Life, 1996). The work of these men reflects the currency of natural medicine and its ability to persevere.

Natural therapies did, however, go through an eclipse in the mid-twentieth century. This was a result of huge changes in society, including the impact of the world wars and the development of highly effective drugs. The kind of medicine practiced in war depended greatly on surgical intervention and the use of the ‘miracle drugs’ of penicillin, opium, morphine, quinine and sulfa. From the 1940s onwards, great advances were made in the West in medical technology, ones that are still being felt today as developments in drug therapy have created major improvements in health. These advances have had a powerful effect in society and enhanced the status and power of the medical profession. The pharmaceutical industry grew in strength as society became geared towards a system of healing that promised and often delivered quick results through the use of these potent drugs. The growth matched a growth in the power and influence of the medical profession and a waning in popularity of natural medicine. Influences of gender, class and state patronage contributed to the rise of medicine from a low status and divided occupation in the 1860s to a high status and politically unified occupation in the 1930s (Willis, 1989). The combination of a rise in effective technologies with a damaged population in recovery from horrific world wars strengthened the rise of reductionism as the dominant and accepted model for health care. The registered profession of medicine received powerful government backing, cementing its authority. This came at a time when society needed established structures to rebuild
confidence in governance. This rise further marginalised the practices and practitioners of natural medicine.

The social revolution that began in the 1960s, called the New Age, propelled natural medicine back into the public eye. It involved a search for values that embodied a return to simple methods of treatment and that rejected the ‘business’ of medicine (Fulder, 1996). The resurgence of interest in natural therapies grew with the swing toward a ‘counter culture’, and a push toward more empowering, patient-focused treatment. The difference in this revival of interest in complementary health care practices was, as Sharma points out, that natural medicine was no longer restricted to ‘small groups of enthusiasts’ (U. Sharma, 1992). This was a time when patients embraced the principles of ‘back to nature’ and sought alternate and complementary treatments to those offered by doctors and hospitals. There was social unrest as young people resisted moves towards war (Vietnam in particular) and sought ways to create a society that had a different set of values and codes of existing. Social structures such as communes (shared living experiences based on an agreed set of values such as vegetarianism, homebirth, organic food) were established and people were encouraged to drop out of the ‘rat race’. Interest in natural medicine increased as it was seen as emblematic of a way of taking power back to the individual and returning to a more ‘natural’ way of life. Courses in naturopathy began to grow then, although education was still inconsistent and self-funded.

Despite growing consumer interest in natural medicine, however, obstacles existed. Legislation enshrined the role and power of conservatively trained medical doctors, creating a power structure it has long proved unwilling to share (Willis, 1989). The dominant medical system contained the growth of natural medicine by ensuring it was not taught in medical schools or universities, that access to research funding was restricted and in general it was disallowed access to any public health care service system (Willis, 1989). Natural medicine was not allowed state licensure or registration and the private providers of naturopathy education did not receive any funding or support.

Naturopathy continued to be taught despite opposition and the culture continued to reflect its philosophical roots. As such it drew, and continues to draw, upon the teachings of Hygeia and Hippocrates as influences in the development of guiding philosophies. This also meant staying true to the seminal teachings of hygienists and nature-cure advocates such as Lust,
Lindlahr, Kloss\textsuperscript{11}, and Bastyr, as well as Kneipp (particularly well known for his advocacy of hydrotherapy, or water cure, and the importance of spirituality in health) and the seventeenth century herbalist Nicholas Culpeper, and continuing to hold to the tenet that all aspects of a human being need to be integrated and balanced, to attain true and lasting health and that health is more than physiological wellbeing. This means that naturopathy is based on principles that seek restoration of mind/body/spirit balance through primarily noninvasive practices and includes the use of medicines such as whole foods and herbs, healthy lifestyle recommendations, bodywork, meditation or spiritual practice, and exercise. The philosophical tenets require the practitioner to recognise that a healthy integration of the three aspects of being (mind/body/spirit) is needed to attain true and lasting health (J.E. Pizzorno & Murray, 1985 ). Indeed, naturopathy draws from the ancestral roots of natural medicine and holds as central the principle that treatment addresses the \textit{whole} person, and does not merely look at disease. These philosophies are central to understanding that spirituality is an important component in the practice of the naturopath.

Much discussion and debate has been undertaken over the years as the profession has worked to strengthen and confirm its core philosophical constructs. In 1989 the American Association of Naturopathic Physicians (AANP) gathered together at the Rippling River Convention to establish a formal definition of naturopathic medicine as a profession defined by its principles rather than the modalities that underlie naturopathic practice. The six principles in the Rippling River definition are used today to create congruence in the profession. They are:

- \textit{Vis Medicatrix Naturae} (translated from Latin as the healing power of nature). The principle relates to an understanding that there is an inherent healing power within the body that is ordered and intelligent. The practitioner works with this power, supporting the healing process by removing obstacles to health, assisting in the creation of a healthy internal and external environment.
- \textit{Tolle Causam} (translated, identify and treat the cause). The principle points to an understanding that, while illness may have many causes, it is important to look deeper than to try to treat the cause of illness, rather than simply treating its symptoms.
- \textit{Primum Non Nocere} (translated, first do no harm). The principle directs natural medicine practitioners to avoid harming the patient and to use therapeutic methods and

\textsuperscript{11} As noted previously, these were men who often held Christian views, which they incorporated into practice, believing strongly in the role of God in a patient’s life.
tools that are noninvasive, that minimise risk and that are supportive of the body's self-healing processes. These methods should avoid the suppression of symptoms.

- **Docere** (translated, doctor as teacher). The principle embodies the concept of self-responsibility for health. The practitioner assists the patient to self-care through education.

- Treat the whole person. The principle requires naturopathic practitioners to recognise that health is affected by a great many factors including those that are physical, mental, emotional, spiritual, social and economic factors. Thus diagnosis and treatment should attempt to take all aspects of a person and their situation into account, and must therefore be individually tailored.

- Prevention. Whole health is about prevention as well as cure and this principle relates to the need for the natural medicine practitioner to assist in the attainment of optimal health through education and the promotion of healthy lifestyles.

(AANP, 1989)

Natural medicine’s guiding principles and philosophies rest strongly on the doctrine of vitalism. Vitalism is a very important philosophical construct and one that lies at the heart of natural medicine. In traditional medicine it occurs when healers talk of a ‘disturbance’ to the body’s innate balance and self-healing mechanism. It can be described as the force that enables a wound to heal without outside assistance (modern medicine describes this as the natural workings of body physiology). Indeed, the humours of Hippocrates are an expression of vitalism within the body. The concept has been examined and researched by healers and scholars (Driesch & Ogden, 1914). However, the concept has its origins in the 1600s in the theoretical works of two physicians, Stahl and Hoffman (Jolliot, 2005). Initially, the theory about the body’s innate self-organising abilities was called **animism**. Animism was said to be a force that coordinated organ function to maintain life. The term animism came to be called vitalism and the theory was taken up by philosophers in France, particularly in the famous school of medicine, Ecole de Montpellier, in the 1700s. At this time there existed a vigorous debate about what vitalism really was and if it really existed (Allen, 2005; Huneman, 2008). It fascinated scholars and scientists as they sought to understand how the body worked and what forces operated in health and sickness (Driesch & Ogden, 1914; Wolfe, 2008). The search for understanding of this unique and somewhat nebulous concept continued amongst biologists and philosophers, until the work of French philosopher, Georges Canguilhem (1904–1995) finally asserted that vitalism acknowledged the spontaneity of life in living matter (Jolliot,
2005). The debate continues. Some scientists consider the belief in vitalism to be a sort of pseudoscience, while others acknowledge a deeper, intangible aspect to health (Hein, 1972).

For the naturopath, vitalism lies at the heart of professional practice. Vitalism is defined as a force within the body that drives the body’s innate self-healing capacity. In this regard, natural medicine is at odds with the reductionist and mechanistic philosophies that underpin modern biomedicine. As noted previously, the concept of a vital force is acknowledged in other healing systems, for example as to as chi or qi (traditional Chinese medicine) and prana (Ayurvedic medicine). The natural medicine practitioner works with the vital force to support a ‘rescuing connection to life-supporting cosmic forces’ (Kaptchuk & Eisenberg, 1998). Lindlahr, an early influential American naturopath, affirmed, ‘just what this vital force is and where it originates we do not know. It is a manifestation of what we term God, Nature, Life, the Higher Power or the Divine Within’ (Lindlahr, 2004 p.273).

Vitalism suggests that the organising force goes beyond mere chemistry and that the healing power of nature requires a different kind of treatment, one that works to assist the body in its own healing process. For example, the migraine sufferer may be encouraged to think about other factors influencing the condition including lifestyle, diet, stress reduction and environmental issues. The naturopath seeks not simply to take away or suppress the symptoms but rather to understand what causes them. The healing work is focused on removing obstacles to the body’s vital force and supporting the body’s innate self-healing capacity. While a mechanistic approach may be to suppress fever, colds and flu the traditional naturopath will take the path of the vitalistic approach, supporting the body’s own self-healing mechanism and working to augment any other therapies that may be being used (Chaitow, 2008). A modern naturopath can utilise and blend different systems of health care. They may read pathology reports as well as conducting a consultation that involves recognising the social/political/economic/spiritual context of the patient and recommending lifestyle changes that are conducive to a healthy life whilst always working to support vital force in an holistic approach that accords recognition of all the factors that influence health – including the spiritual side of life.

Naturopaths are said to work *holistically*. Derived from the Greek word, *holos*, holism it is used to describe the concept of treating the patient as a whole. The term was coined by Colonel Jan Smuts, a South African statesman, in 1926 in his book *Holism and Evolution*,
where he described Africa as a country, the sum of which was bigger than the parts (Smuts, 1926). The word has traveled widely into the modern lexicon and is particularly used in reference to naturopathy. It is what Fulder refers to as a ‘global treatment with as much emphasis on psychological and preventative care as on the treatment of pathologies’ (Fulder, 1996 p.10). The practical expression of this is long consultations that view a patient in context (an echo of bedside medicine), looking further than at a short-term response to any specific condition; treating causes rather than simply eradicating symptoms and addressing health as an integration of mind/body/spirit. A patient is viewed as a complex web of integrating and interconnected body systems and subtle energies. The practitioner supports the body in the natural self-healing process, working as noninvasively as possible to create a balance in the flow of energies in the body. This style of practice aims to facilitate healing by assisting and encouraging the body’s vitalistic force to do its work. A practitioner who follows these principles is said to treating a patient holistically.

Vickers describes holistic treatment as including the following factors: it recognises that the body has an inherent ability to heal itself; treatment should stimulate this capacity; it seeks the root of the disease/problem treats not only the body but also the body/mind/family/environment; there is time to talk, touch (as appropriate) and listen to the ‘story’; patient participation is encouraged; spiritual or religious beliefs are respected and discussed where necessary; and therapy may include doing something supportive in the clinical setting such as advising different types of counsel or recommending bodywork (Vickers cited in Foster, 2006). Both medical and nursing practice may incorporate these factors as well. In naturopathy however, these considerations are seen as being fundamental to practice.

Medical systems of belief evolve as knowledge and different kinds of expertise are discovered and developed over time. A recent advance in biomedicine is the adoption of evidence-based medicine (EBM). This particular methodology for organising practice and categorising care has had huge implications for health care practice and education, and for natural medicine.

The challenge of evidence-based medicine

Evidence–based medicine (EBM) is described as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). In theory, evidence-based medicine draws
upon the best external information in treatment coupled with the clinical experience of the practitioner and the patient’s choice. The evidence is placed into a hierarchy described below. The golden mean for establishing authority of treatment is the randomised-controlled trial (RCT). At the bottom of the list is clinical anecdote, that is ‘knowledge gained from the clinical experience of the practitioner’ (Clarke, 1999 p.91). This can be taken to mean that the mechanistic model of the RCT is considered more valuable or true that the empirical knowledge gained through experience and over time. Within the scientific model the evidence hierarchy is seen as relating to the degree of independence of the observation and the degree to which potential bias has been reduced. In this light a clinical trial is seen as having more external independence than a clinical (empirical) experience. Through the use of randomisation and blinding, the bias associated with the observation is reduced.

The National Health and Medical Research Council (NHMRC 1998 p.8) in Australia, grades evidence (or research findings) according to level, quality, relevance and strength. The following table illustrates the approach:

<table>
<thead>
<tr>
<th>Level of evidence:</th>
<th>Study design used as an indicator of the degree to which bias has been eliminated by design</th>
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</thead>
<tbody>
<tr>
<td>I</td>
<td>evidence obtained from a systematic review of all relevant randomised controlled trials</td>
</tr>
<tr>
<td>II</td>
<td>evidence obtained from at least one properly designed randomised controlled trial</td>
</tr>
<tr>
<td>III–1</td>
<td>evidence obtained from well designed pseudo-randomised controlled trials (alternate allocation or some other method)</td>
</tr>
<tr>
<td>III–2</td>
<td>evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group</td>
</tr>
<tr>
<td>III–3</td>
<td>evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group</td>
</tr>
<tr>
<td>IV</td>
<td>evidence obtained from case series, either post-test or pre-test and post-test.</td>
</tr>
</tbody>
</table>

The ranking raises challenges for the practitioner of natural medicine. The shift in valuation of knowledge towards RCTs causes concern in that: ‘The core content of disciplines such as naturopathy, herbal medicine and TCM is based in empirical clinical experience. If these kinds of evidence are ignored many complementary therapists would be ignoring the current basis of their practice knowledge’ (Hunter & Grant, 2005 p.11). Members of the natural
Evidence-based medicine is symptomatic of a way of thinking which has developed in line with a certain philosophy of medicine. When it appears that a seemingly exclusive ‘scientific’ model is used to provide standards in the provision of health care, then it is not surprising that it should include a methodology that excludes to a large extent experience and tradition and favours laboratory-based models of measure and management. As Sigerist notes: ‘the medical idea of a period also determines its system of medical education, for its purpose is to train a physician according to a certain educational ideal which in turn is the medical ideal of the time’ (Sigerist, 1987 p.272). This reminds us that the role of the educator is critical in determining the relevance and future of practice. The introduction of EBM represents a shift in the culture of training and, as such, the role and implementation of EBM needs consideration in natural medicine education and practice.

The division between biomedicine and natural medicine is accentuated by the push towards EBM as there has been historically very little external ‘scientific’ research done in the re-emerging profession of naturopathy. The reasons are historical. In the past natural medicine lacked official recognition and had little or no access to funding for research. Research is commonly funded by private-sector interests who might see the economic benefit of a certain procedure or product. Until the huge uptake in the services and products of natural medicine in the latter half of the twentieth century (Eisenberg, et al., 1993; MacLennan, et al., 1996), funds did not flow into research in natural medicine. In recent years the situation has changed and although naturopathy remains an unregistered profession in Australia, there is growing access to funding for research. In 2007, for example, the Australian Government funded the National Institute for Complementary Medicine Research (NICMR) with a $5 million grant. With a change of Government funding for this agency was cancelled and NICMR was closed at the end of 2009. A Therapeutic Goods Administration (TGA) was also established in Australia in 1989 along with the Therapeutic Goods Act (1989) to monitor and assess therapeutic goods and claims as the increasing intake of supplements has led to increased regulation on health claims. This, in turn, has boosted research on items considered ‘natural’ such as fish oil, herbal and vitamin supplements.
Chapter 3 – Foundations of Naturopathy in natural medicine

It has been argued that the protocols used by EBM (e.g. population-based studies) are not suited to a profession whose epistemology is based on the context of the individual (Tonelli & Callahan, 2001). White & Willis argue that the location of EBM within the positivist paradigm means that the ‘social, cultural and biographical features of the individual are swept away’ meaning that there is a reductionist model being imposed on the practice of natural medicine (White & Willis, 2002 p.10). They suggest that the push for EBM is a paradigm shift, and express concern that the construct is part of an attempt by biomedicine to co-opt the practices of natural medicine, whilst avoiding any associated philosophical underpinning. This concern has been expressed in debate in the literature regarding the influence and impact of EBM as a practice model (Frohock, 2002; Gupta, 2003; Jagtenberg, et al., 2006; Mills, et al., 2002; Sackett, et al., 1996; Sampson & Vaughn, 2000; Straus, 2004; Tonelli & Callahan, 2001; Willis, 1994).

At a fundamental level, critics of EBM are in fact commenting on the limitations of positivism with special reference to its usefulness in the context of healthcare and healing. As Horowitz (2004) points out, the positivist perspective goes with certainty, yet health and healing are by no means certainties and can contain immeasurable unknowns that effect cure – such as faith. Smith (1987, 2002) also writes about the limits of positivism, on epistemological grounds. While positivism has become the dominant perspective in health care practice in the West, it sits uneasily with the naturopathic paradigm of holism and vitalism. The two constructs are in opposed to each other, in that positivism appears to exclude the variables of the holistic paradigm.

An approach with intellectual bite that can accommodate this seeming polarisation of positions is hermeneutic in nature. An hermeneutic perspective enables an understanding of the phenomena of health and cure as having many disparate elements that make up the whole. Hermeneutics, as described by Gall et.al (1996) is a field of enquiry that seeks to interpret human phenomena by understanding how different parts relate to the whole, differences are not necessarily antithetical, and understandings are not necessarily exclusive of each other views. Instead the different viewpoints, taken together provide a vehicle for deeper understanding to be read into a phenomenon. Interpretation is at the heart of hermeneutics. (p.631). It is a deeper conceptual framework than either positivism or holism. An hermeneutic scaffold permits multiple interpretive practices, none of which is privileged over another. As explained by Denzin and Lincoln (2003), philosophical hermeneutics argues that
‘understanding is not in the first instance, a procedure or rule governed undertaking; rather it is the very condition of being human. Understanding is interpretation’ (p.301). This construct is inclusive; the specifics of positivism and the immeasurable elements of the clinical exchange all have validity. (Interestingly and curiously appropriately, the word hermeneutics derives from the name of the Greek god Hermes. He was the one who was the messenger and interpreter of messages from the Gods).

However, the ideological differences in theoretical approaches of holism and positivism have contributed to the ongoing turf war between natural medicine and biomedicine. The successes of natural medicine are to a large degree anecdotal. As Richardson points out, the evidence base is limited, as there simply haven’t been enough studies done to create a substantial body of evidence to support the profession (Richardson, 2002). The oral tradition and ‘folksy’ culture of reporting may have kept the authenticity of purpose but have also worked to hinder acceptance of the profession. Mills and colleagues argue strongly for the importance of developing an EBM culture in natural medicine in order to bring the profession greater integration into the health care system, and to be able to have subsequent influence upon policy (Mills, et al., 2002). There are barriers to this ambition, mainly the divergent philosophies of naturopathy and biomedicine and the concern that the adoption of EBM threatens naturopathy at a philosophical level. These concerns relate more to understanding what EBM actually represents and how it is translated into practice.

Mills notes that naturopaths can be suspicious of the medicalisation of treatment to the extent that it takes away the highly individual nature of a typical consultation (Mills, et al., 2002). Richardson argues that EBM has limits and that the ‘murky depths’ of consultation is where deep understanding happens (Richardson, 2002). The development of a culture accepting of and conversant with EBM, requires a shift in the educational focus. When Richardson talks about the swampy lowland situations, which are confusing messes, she is talking about the murky heart of the therapeutic relationship (Richardson, 2002). It is argued that the human condition is not neat and the desire to reduce it into manageable chunks able to be measured by the positivist epistemology of EBM, could be seen as an extension of the mechanistic paradigm. Holmes, Murray, Perron and Rail argue even more strongly for a review of the push for EBM, stating that the evidence-based movement is ‘outrageously exclusionary and dangerously normative with regards to scientific knowledge’, and, in regards to health, amounts to a kind of microfascism because the colonisation of the profession by such an
exclusive research paradigm necessarily excludes alternative kinds of knowledge (Holmes, Murray, Perron, & Rail, 2006).

EBM offers to some proponents a simple, clear and logical guide to making treatment decisions and making practice more effective. To others it represents a cooption of natural medicine, subtly and irrevocably changing the context of the profession, rendering the philosophies superfluous and irrelevant. More strongly still, it is argued that the unchecked advancement and blanket acceptance of EBM amounts to nothing less than an extension of the hegemonic control over health care by the biomedical sciences (Holmes, et al., 2006). This hegemony brings forward issues such as who gets to decide what sort of health care should be funded by the public purse. The debate is ongoing and the arguments are vivid.

The covert power struggle creates its own problems for those affected by it (Hunter & Grant, 2005). For example, the inclusion of EBM as a validated and dominating model for assessing the efficacy of therapeutic practice has an impact on the educational practices of natural medicine. Similarly, EBM, using the RCT as the golden standard for validity, causes problems when it comes to the inclusion of spirituality and religion as valuable and necessary components of practice. Koenig (Koenig, 2008) points out that it is possible to conduct research on health and religion, as religion is a measurable, understood concept however spirituality is a concept that is difficult to define and often varies in nature from individual to individual. He also notes that results gathered from the research can be used to help understand those who call themselves spiritual, as this is a common expression of faith. Also spirituality and religion have become less well regarded in the Western model of biomedicine as they represent ‘soft’ ways of viewing health. They can be difficult to measure, and can be seen to complicate what might be viewed as a simple clinical condition. Yet there are many in the population who would call themselves spiritual or spiritually directed and consider that to be part of their philosophy of life. Kleinman states:

Social reality is so organized that we do not routinely inquire into the meanings of illness any more than we regularly analyze the structure of our social world. Indeed, the everyday priority structure of medical training and of health care delivery, with its radically materialist pursuit of the biological mechanism of disease, precludes such an inquiry. (Kleinman, 1988 p.9)
Kleinman describes a value system in modern health care whereby psychosocial concern is ‘soft’ [which means devalued] as opposed to ‘hard’ [which means overvalued] in the technical quest for the control of symptoms (Kleinman, 1988). But natural medicine can and does excel in the delivery of a patient-centred healing practice, which listens, observes and respects the multifaceted layers that make the weave of personal health. This is where natural medicine runs at odds with biomedicine. The focus in one system is on the symptom(s) and associated pathology. In the other the focus is inclusive and holistic, acknowledging that a balance of mind/body/spirit is essential for creating and sustaining long-term health and wellbeing. In this regard naturopathy has stayed true to its historical antecedents in natural medicine and maintained regard for spirituality as an implicit component of health.

The conflict in philosophical approaches to healing, between EBM and holism, comes at a time when natural medicine is becoming much more important in society and its practices and therapeutic tools are more understood and widely used. The dominance of biomedicine and the rise of EBM represent another shift in the long history of knowledge about health and healing. How spirituality, once regarded as central to understanding illness, has survived in naturopathy and is reflected in the education of naturopaths is the focus of the research.

Concluding remarks

This chapter has shown the shared roots between natural medicine and modern biomedicine. It has described a time when the main model of health care was more inclusive and people were viewed in their surroundings and in the context of their beliefs and spiritual and social beliefs were factored into health care. The change that began with The Enlightenment promoted a split with the philosophies of natural medicine and its vitalistic approach and sped up a dualistic approach over the last 200 years. The model has been amplified with the rise of biomedicine and increasing dominance of technology. These medical models of practice sit uneasily with the practice of natural medicine. Here the difference in approach is stark.

The shift in empowerment sits at the heart of the science vs. tradition split that is being argued today. The roots of naturopathy and current practice lead the naturopath to working holistically, respecting the body’s self-healing capacity and looking at creating a healthy balance of mind/body and spirit in their patients. This central philosophy is the key to authentic naturopathic practice and dictates a style of practice that returns to an inclusive
model, which acknowledges and accepts ways of knowing and believing and how they influence health. Whether the culture of education is reflecting and honouring traditions and philosophies as important remains to be seen. It certainly has long-term implications for the profession.
Chapter 4

Naturopathy and spirituality

This chapter addresses the nature of the relationship between naturopathy and spirituality. In the West, ever since the time of the ancient Greeks, notions of spirituality have been intertwined with the practice of natural medicine, so much so that spirituality is now widely accepted as being a foundational concept for the practice of naturopathy. Spirituality is, of course, also a foundational concept for the practice of religion. Not surprisingly then, there is a literature on the relationship between a religious commitment and the attainment and maintenance of good health. This literature is not, however, considered to any great extent in the chapter. Of greater concern is the place of spirituality in naturopathic practice. The chapter begins with an account of the nature of spirituality. It then reviews the literature on the role of spirituality in relation to healing; noting that research on religion is often transferred to spirituality, as this is a current expression of demonstrating faith. Finally, it focuses on the particular relevance of spirituality to naturopathy.

The nature of spirituality

The word, spirituality, derives from the Latin word, spiritus, meaning breath and signifies an individualistic belief system. Spirituality is a generalist term that is also particularised in personal expression. It resists a neat, one-size-fits-all definition and may shift from person to person and as one grows and develops. The classification of the concept of spirituality is, accordingly, difficult (Cawley, 1997). Followers of an Indian guru may end up being Quakers or atheists while all the time considering themselves to be spiritual persons. The shift in society away from the church is creating a secular form of spirituality that is extremely subjective and diverse and highly individualised meaning different things to different people (McSherry & Cash, 2004).
The struggle for definition is complex. Spirituality does not necessarily have a Christian foundation. It is described as multi-dimensional, about the search for meaning in life, concerned with connecting with the sacred and a ‘never-ending endeavour to find out the link between the finite and infinite’ (Fitzgerald, 1997). Chilton extends the meaning to encompass an inner strength related to a belief in, and a sense of interconnectedness with, a higher power (Chilton, 1998). It is defined as connecting to systems such as God, nature or other people and thus finding meaning through relationships (Friedmann, Mouch, & Racey, 2002). Thoresen nominates spirituality as ‘the search or quest for the sacred in life and beyond, a seeking of answers to life’s most meaningful and vital questions’ (Thoresen, 1999 p.293). Mattis observes that spirituality is the internalisation of positive values (Mattis, 2000). Other writers bring to the discussion the notion of *transcendence* (Fry, 1998). Aldridge notes that ‘spirituality lends meaning and purpose to our lives; these purposes help us transcend what are’ (Aldridge, 1991 p.76). Transcendence can be a sense of connectedness with God or a higher consciousness, or it can be interpersonal and embody inner knowing and strength, developed as a resource through a sense of spiritual connection with life.

McSherry and Cash argue that a universal definition of spirituality is virtually impossible, moreover that attempting a definition is restrictive as its meaning is so highly individualised (McSherry & Cash, 2004). However in a scholarly attempt to organise some of the confusion that a discussion about the concept of spirituality can generate, they have devised a taxonomy that breaks down the various components of meaning. The taxonomy breaks down some of the many ways people understand spirituality and how it instills meaning into their lives. It uses descriptors such as theistic, religious, language, phenomenological, existential and mystical as tools to deconstruct the concept of spirituality and give insight into the depth and complexity of this nebulous and significant term. The development of the taxonomy shows how complex and subtle the meaning is.
Taxonomy of spirituality

<table>
<thead>
<tr>
<th>Descriptors</th>
<th></th>
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<tbody>
<tr>
<td>Theistic</td>
<td>Belief in a supreme being, cosmological arguments not necessarily a ‘God’ but deity</td>
</tr>
<tr>
<td>Religious</td>
<td>Affiliation – a belief in a God, undertaking certain religious practices, customs and rituals</td>
</tr>
<tr>
<td>Language</td>
<td>Individuals may use certain language when defining spirituality such as inner strength, inner peace</td>
</tr>
<tr>
<td>Cultural, Political, Social Ideologies</td>
<td>An individual may subscribe to a particular position or social ideology that influences, governs their attitudes and behaviour – dependent on world faith – religious tenets</td>
</tr>
<tr>
<td>Phenomenological</td>
<td>One learns about life by living and learning from a variety of situations and experiences both negative and positive</td>
</tr>
<tr>
<td>Existential</td>
<td>A semantic philosophy of life and being, finding meaning purpose and fulfillment in all of life’s events</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Although quality of life is not explicit in definitions it is implicit</td>
</tr>
<tr>
<td>Mystical</td>
<td>Relationship between the transcendent, interpersonal, transpersonal, life after death</td>
</tr>
</tbody>
</table>

CONSIDERATIONS

The order or sequencing of the descriptors present in the taxonomy are individually determined depending upon one’s beliefs, values and life experiences or worldview.

The taxonomy is restrictive in that it implies the ability to intellectualise, supporting the position that such definitions are exclusive and restrictive.

The taxonomy implies that an individual’s world view will determine their view of spirituality.

The descriptors listed in the taxonomy are not exhaustive because they may well be infinite.

The taxonomy suggests two forms of spirituality ‘old’ and the ‘post modern’. The old = religious and theist while the ‘post modern’ and existentially focused.

(McSherry & Cash, 2004)

Swinton (2006) argues strongly that there is a need for critical thinking in the debate with particular regard to the use of the word ‘spirituality’. He argues that using the concept spirituality to describe a generic way of being trivialises an important human construct. The imprecise definitions are caused in part by the change of spiritual connection in modern society, reflective of the shift in social values (Swinton, 2006). Jurisson argues against the assembly of an eclectic bag of spiritual practices, questioning if the process somehow removes the reverence and makes it nothing more that a number of techniques which can be self-serving (Jurisson, 2000). Tacey argues that the emergent social approach is a positive, part of a spiritual revolution, one whereby a new kind of spirituality is emerging that is existential rather than creedal, meaning people are making their own definition of spirituality according to their own needs and ideas (Tacey, 2000). Spirituality, despite being described
and discussed remains elusive, individual and idiosyncratic according to who is utilising the term. The debate is reflective of the renewed recognition and emphasis on spirituality in the public domain.

Religion on the other hand is a much more understood term and one that can be classified. Religion comes from the Latin word, *religare*, meaning to bind, and it is used to describe the formalised set of practices that adhere to belief in a particular god and is reinforced by a code of behaviour such as going to church on Sundays, or praying at specific times and on days noted as holy or sacred. Chilton notes that whilst religious practices can encompass spirituality, spiritual practices need not be religious (Chilton, 1998). Moskowitz describes religion as a methodology for expressing spirituality (cited in Jonas & Crawford, 2003). Religion is described as the organised system of beliefs, practices and rituals and symbols that are designed to facilitate closeness with the sacred and provide the average person with moral and social guidelines for behaviour (Thoresen, 1999). What is common is that religious practice often includes membership of a group or community of like-minded individuals following a set of prescribed rituals, for example, taking communion or praying to Mecca five times a day. The practice also often involves regular meetings and guidance talks (sermons) about how to manage and understand the vicissitudes of life.

Eckersley (2007) draws on the big picture to describe spirituality and religion in the context of culture. He notes that spirituality is a deeply intuitive, but not always consciously expressed, sense of connectedness to the world in which people live. Its most common cultural representation is religion, an institutionalised system of belief and ritual worship that usually centres on a supernatural god or gods (presumably goddesses as well) (Eckersley, 2007). In the past the strong institutions of religion provided guidelines for morality which helped shape culture. However, cultural meanings shift and, as Eckersley notes, when the spiritual content of religion is ‘hollowed out’ and replaced with materialism, nationalism and fanaticism then its social value is diminished (Eckersley, 2007). People may refer to themselves as spiritual and religious, or spiritual but not religious (Zinnbauer, Pargament, & Scott, 1999). They may state that they do not believe in God, but that they do acknowledge a power/force beyond themselves (McSherry & Cash, 2004). Pargament grapples with the ‘split’ noting that both concepts are evolving in social consciousness (Pargament, 1999).
It is however these constructs that can present in naturopathic practice and influence prescription and health care recommendations. Accordingly the naturopath needs to be aware of the belief systems held by patients. Spiritual and religious beliefs held by patients can be complex and can work against health (mass suicides following a cult leader receiving messages from above is an extreme example). One that might occur for a natural medicine practitioner could be a woman following strict vegan dietary guidelines and refusing to eat any animal food (including dairy and eggs,) being cold all the time, extremely thin and having her menstrual cycle cease. Knowledge of the constructs that shape patient decision making will have influence on the way naturopaths address the issue with their patients.

Spirituality and healing

The desire by humans for connection with a power outside of themselves has long played an important role in the development of healing practices. Ritual, ceremony, temples and churches all mark the historical and geographical landscape of humankind as the striving for connection and seeking for help and guidance from the divine is a central theme in the story of civilisation. The rapid development of biomedicine in the twentieth century followed the principles of dualism and created a model of health care that is symptom-based and pathology-focused. However, the relationship between healing and spirituality is deeply entrenched and a different model existed historically, one that was patient-centred and linked health with spiritual wellbeing and connectedness. The history of medicine shows how deeply intertwined health and spirituality have been over time. Traces of the relationship remain. The Hippocratic Oath that graduating doctors of the study of medicine once swore to the gods and goddesses reminds us of when healing was seen in a more complex and interlinked way. The Rx symbol written by doctors today on prescriptions is commonly used and in modern use believed to stand for the Latin word, *recipe*, meaning ‘take’, however it links the modern practitioner back 5000 years to an Egyptian medical cult. The crossed R represents the eye of Horus, a falcon-headed god, who lost his eye in a childhood fight. His mother Isis took him to Thoth, the medical god, who healed him by spitting in his eye. Thus spittle was accorded healing powers and the eye became a symbol of divine protection (Bondi & Bullock, 1969). This obscure connection shows up the subtle links of a more spiritually connected tradition in modern medicine.
Originally, the healing arts were considered a gift from the gods. This meant that illness was often seen as punishment for sin, a chastisement from above, and treatments such as fasting and purges would have overtones of purification rituals. The Christian church historically offered a structure for the delivery of treatment to a needy society as part of its healing mission. Medieval monasteries were places where monks offered places for healing and restoration through their herb gardens and the offering of sanctuary as a place for rest and recovery. Other health workers in society such as midwives, herbalists, witches, shamans and priests with their tools and rituals all worked to offer help, treatment and mechanisms into understanding disease and for achieving health and balance. The Church and its agents was the main conduit for healing help for many hundreds of years. St Basil, the Bishop of Caesarea, received a message from God in AD 370 to clothe the poor and heal the sick and as a consequence of this divine injunction he instigated the creation of the first hospital (Bondi & Bullock, 1969). In the Middle Ages the monasteries became centres for care of the poor and sick. Monks and priests acted as physicians and sanctuary was more about convalescence than the political meaning it has today. Herbal medicine flourished and the church was largely responsible for granting permission for people to work as healers and for the running of hospitals. There was a period around the year 1200 when there was an upsurge in hospital building and establishment of universities. Healing shrines flourished and saints became popular for their restorative powers. The Crusades spread the development of religion-based hospitals as the Knights Templar built hospitals on their travels throughout the Mediterranean and Europe. Medicine spread, always strongly linked with religion, until the beginning of the Renaissance period around the 1400s when, in Britain, doctor certification began to be taken over by the state. This occurred around the time of the bubonic plague when health became a public matter and government officialdom was called upon to make changes to safeguard the health of the population. While this may have meant sealing afflicted people in houses – a draconian measure – it also signified the increasing power of the state through public health measures such as implementing better drainage and the control of vermin. However, the links with spirituality and religion and health were not severed. The charitable works of the major religions nearly always involved caring for the sick and the poor. Nuns were the first nurses working in hospitals run by the religious institution founded in 1633, The Daughters of Charity, Servants of the Sick Poor (later ‘of St. Vincent de Paul’). Later the Society of Friends

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12 Various saints, while working as conduits for spiritual connection, had special connotations. St. Luke and St Michael were all-purpose saints whereas others were seen as specialists, usually because of some ailment they had cured or been cured of in their lives. For example, St. Margaret was the patron saint of women in labour, St. Fiacre specialised in sore arses (sic), St. Blaise was good for goitre and St. Sebastian was helpful in times of pestilence – plague and syphilis being the most famous and deadly (Porter 1997).
(Quakers) ran mental hospitals (1800s) and organized religions continue to run hospitals and sponsor missionary doctors. There is a strong connection between spirituality/religion and health that is evidenced in the historical lead up to the current growth of spirituality as an expression of a belief in forces outside the temporal body. While historically religion took up the issues of health and care (and still does to some extent), today with the shifting to a more secular spirituality, there is a resurgence of the philosophical constructs of spirituality (not necessarily religion) as important in health.

The link between spirituality and health continued into modern times. In the early part of the nineteenth century, psychiatrist and doctor W.H.R. Rivers wrote about the convergence of religion and medicine as practiced in indigenous societies, presenting his work to his conservative colleagues at the Royal College of Physicians, London, in 1915, during a series of lectures about the need to view medicine in its cultural context, to better understand its validity. Sir William Osler, the father of modern cardiology, wrote in 1910 in the British Medical Journal (BMJ) about faith in health care.

Nothing in life is more wonderful than faith – the one great moving force which we can neither weigh in the balance nor test in the crucible … Faith has always been an essential factor in the practice of medicine … Not as a psychologist but an ordinary clinical physician concerned in making strong the weak in mind and body, the whole subject is of interest to me (Osler, 1906p.1470).

Osler wrote about aequanimitas (good will), a concept that embodied paying attention to the spiritual needs of patients (Osler, 1906). In 1902 William James, a formative influence in the development of American psychology, wrote about the effect of religion on health in his book, The Varieties of Religious Experience (James, 1958). The work discussed spiritual health and soul sickness, and suggested scientists should not ignore the unseen and immeasurable because of the important role it plays in people’s health.

The medical historian, Sigerist, notes that up until the mid-nineteenth century the art and practice of medicine was seen as a continuum of philosophies and ideas, built upon the practices and experiences of preceding generations (Sigerist, 1987). However, the ascent of biomedicine changed the approach to health care. Boosted by the seemingly miraculous healing powers of antibiotics and effective government health schemes involving clean water and better civic hygiene, public health outcomes began to change. At this time, as Sigerist
observed, ‘the past seemed dead’ and the practices of the past were a ‘history of errors’ (p.4). The dominance of biomedicine and its largely reductionist construct as the primary health care system meant that the value of recognising the spiritual, cultural and social context of a patient has been much diminished in the West as practice centred on positivist protocols which, by and large, focus on the relief of symptoms and associated pathologies. Historically, the inclusion or observance of matters spiritual may have taken different forms (e.g. prayer, séance, shamanistic ritual, practices such as placing of symbolic tools and objects in the sick room). All these rituals existed as evidence of the human desire to tap into other sources for healing, help and succour in times of illness and distress. While they have become marginalised, in the latter part of the twentieth century and into the twenty-first, there has been another shift with a rise in interest in reclaiming the spiritual aspect of healing (Koenig, 2001).

There is an increasing volume of research on the role and relevance of spiritual and religious practice in long-term health and wellbeing (Ferraro & Albrecht-Jensen, 1991; Koenig, 2000c; Post, Puchalski, & Larson, 2000). As noted earlier, research is conducted on religion rather than on spirituality, as religion is a more quantifiable concept. The results, however, are often transferred to the concept of spirituality.

In the beginning of the twenty-first century, over 2,000 papers were published in medical and nursing literature (Jonas & Crawford, 2003) discussing the role of spiritual and religious beliefs in health. In 2006 alone there were more than 70 published research papers investigating the nexus between religion, spirituality and health, many finding positive connections. Data shows a range of findings about the efficacy of intercessory prayer (Byrd, 1988; Dossey, et al., 1993; Jantos & Kiat, 2007) and distant healing (Astin, Harkness, & Ernst, 2000) and that overall, people are healthier when they lead spiritually directed lives (Byrd, 1988; Thoresen & Harris, 2002). In 2001 eminent researchers Koenig, McCullough et al. published *The Handbook of Religion and Health*, which had a stated aim to review and discuss research that has examined the relationships between religion and a variety of mental and physical health conditions (Koenig, McCullough, & Larson, 2001). The analysis is critical, comprehensive and systematic and included more that 1,200 studies and 400 research reviews conducted during the twentieth century. The work concluded that overall there was a positive association between spirituality and religion (Koenig, et al., 2001).
In Australia there has been a rise in interest in the spiritual component of health. Koenig cites that 74% of Australians believe in God or a higher life force and that this aspect of life continues to matter, despite a largely secular and materialist society (Koenig, 2003). In 2007 the Medical Journal of Australia (MJA) ran an issue dedicated to the topic of spirituality and health. Williams & Sternthal report that Australian patients want their practitioners to incorporate spirituality into their assessment and treatment protocols (Williams & Sternthal, 2007). The research strongly indicates that this component of health has ramifications for practitioners and they may experience within themselves uncertainty when faced with patients’ expressed desires to talk about their spiritual needs. However, denying or sidestepping the need demonstrates a lack of acknowledgment that people’s individual narratives of health are deeply meaningful to them. The research goes further to indicate that absence of recognition and validation of something that matters to patients can further contribute to their suffering and almost certainly diminish the patient/practitioner relationship. Aldridge (2005) notes that fears and doubts about its place in everyday health care practice need to be put into perspective.

Research indicates that people who are spiritually directed, or have a consistent religious practice show evidence of greater marital stability, less alcohol and drug use, lower suicide rates, less anxiety and depression (Koenig, et al., 2001). These behaviours are also associated with less cigarette smoking, less stress (especially with meditators because of the mind-stilling exercises that are part of the practice), lower blood pressure, lower cholesterol, more conservative sexual practices and associated lower STDs (Koenig, 1999). George and colleagues report that data steadily shows a positive relationship between religious and spiritual practices and positive health outcomes (George, Larson, Koenig, & Mc Cullough, 2000). Koenig observes that if you are in a community that is aware of you and assists you in times of trouble and if your spiritual/religious community promotes fidelity and discourages promiscuity and drug/alcohol abuse then those lifestyle choices would be reflected in your health (Koenig, 2007). Similarly, if the supporting community discourages smoking and promotes social events that help preclude loneliness then there is a predisposition to have improved health. Struve reports that spirituality and religion affect all of the five main health indicators; mortality, health-related quality of life, disease presence/absence/severity, health service utilisation, specific conditions and functionality (Struve, 2002).
Within society there is evidence that spiritual convictions have a positive impact on health and wellbeing. For example, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are widely regarded as having the most effective programs that help with alcohol and substance abuse. The twelve-step program that underpins the approach is founded on a principle that there is a higher power and that getting healthy means acknowledging and surrendering to this. Participants are not required to be spiritual per se but the spiritual guidelines of the program are central to its success. Conservative religious groups such as the Seventh Day Adventist and Mormon communities that promote abstinence from alcohol, red meat and tobacco have long been studied, as they are well known for their improved health outcomes. These communities provide evidence of the link between spirituality and health, when people adopt moral and spiritual codes for living that impact positively on health (Jamison, 2001; Mullen, 1990).

Puchalski & Larson go so far as to suggest that healing does not really turn on the question of recovery but instead turns on the spiritual side of life (Puchalski & Larson, 1998). Accordingly, attention to and inclusion of the research work done in the field of spirituality, religion and health would seem to be appropriate in the education and training of health care practitioners. Acknowledgement of the role of spirituality in health and healing is shown in the education practices of allied health professions. Currently, 72 of 126 medical schools in the United States have included in their curricula electives, or required courses on religion, spirituality and medicine (Koenig, 2000a; Peach & Gijsbers, 2003). While Australia is largely a secular society, awareness of the spiritual and religious needs of patients is growing and spirituality was introduced as required component in the teaching curriculum at the University of Sydney Medical School in 2007. It is interesting to note that Australia’s oldest and largest medical school decided, in response to feedback from a course review, to introduce spirituality into the education and training of doctors as it was deemed both necessary and appropriate that the training be broadened to be more inclusive of patient need.

Prayer

A mention needs to be made about prayer and its role in creating a positive atmosphere with patients. Prayer has been defined as the active process of communicating and appealing to a higher spiritual power (Jantos & Kiat, 2007). It has been used for centuries to alleviate pain, distress, suffering and ill health and is demonstrated by uttering a repetitive prayer, sound,
word (like a chant). Studies on prayer are ongoing but it is recognised that prayer is a powerful coping tool and can play a significant role in improving a patient’s outlook and their optimism, as well as offering consolation and support in times of spiritual and physical distress. Naturopaths may not necessarily pray with their patients but they can recognise and respect its importance. Knowledge and awareness of a person’s spiritual beliefs can empower the patient, foster co-operation and contribute actively and positively to the treatment plan (Koenig, 2006; Pargament, 1999; Sorajjakool, Thompson, Aveling, & Earl, 2006). It is discussed in greater detail in Appendix 8

Spirituality and naturopathy

The consideration that spirituality is a key component of health has always been a part of naturopathic philosophy and traditional health care practices. The philosophies of vitalism and holism are integral to naturopathy and these philosophies are inclusive of an acknowledgement that there are subtle and apparently immeasurable aspects to health. The vitalistic and holistic model incorporates the principle that a healthy body is one where mind, body and spirit are synthesised and balanced within a harmonious way. The fundamental principles of holism in particular are based on a belief that true health resides with an integrated balance of mind, body and spirit. These principles are distinguishing features that differentiate biomedicine from naturopathy. This essential philosophy underpins a model of practice that works with the body’s innate self-healing capacity (vitalism) and embraces all aspects of a person’s being (holism) to help them toward health. The mind/body/spirit nexus connects the healing approach with that of the ancients who talked and wrote about working with and respecting nature as an embodiment of spirit and higher forces. The belief that spiritual wellbeing is integral to health connects the natural medicine model with the long recognition of the relationship of humans to a higher power, one that exists within and without the body and is key to long-lasting health. The influential nature-cure hygienists who worked in the United States in the early nineteenth century such as Kneipp, Kloss and Lindlar were often deeply Christian men who taught that living by nature’s laws was a way of obeying God’s will. They would propose, for example, that illness happened when people did not follow the laws of nature, and that a return to health, whilst incorporating sunshine, fresh air, rest and wholesome food, also meant living a moral life. These principles of

13 Dr T. Still, the father of modern osteopathy, was a Methodist Minister
‘natural’ living had a spiritual foundation and this ethos still holds in naturopathy today when naturopaths talk about spiritual wellbeing as a key component of health.

A truly holistic treatment approach requires more than the simple substitution of tools (for example, using a herbal medicine instead of a synthetic drug). While this strategy can contribute to the wellbeing of a patient, it is referred to as a green prescription – one that uses the mechanics but does not incorporate a philosophic commitment to holism on the part of the practitioner. Professionals who use this approach are involved in cooption, where one profession uses the traditional tools of another profession but with a disregard to guiding principles. Practitioners such as these are called green allopaths (Baer, 2001; Crellin, 2006). This is practice in a non-holistic, reductionist manner whereby the tools have shifted but there is not any deep philosophical integration into practice (Wohlmut cited in Robson, 2003)\(^1\). There is not necessarily in this form, any acknowledgement of spirituality as a component of health.

Astrow and Puchalski observe that illness gives patients many choices – between hope and despair, frustration and resolution, blame and responsibility (Astrow & Puchalski, 2001). For the naturopath, dealing with and acknowledging this internal struggle as part of the process of health and healing can provide challenges in practice. The naturopathic practitioner is often required to deal with complex and chronic conditions for which there has been no easy solution and this means that patient can bring with them substantial ‘baggage’ which will be in the diagnostic mix. Spiritual distress and confusion may well be part of this and will test the confines of the clinical relationship. However spiritual wellbeing is one of the key pillars of the naturopathic model for health and accordingly needs to be part of practice protocols. There is ample research done in the field demonstrating the links between spirituality and health and so it would seem both fitting and appropriate that educational practice in health care reflect these principles.

There are difficulties and limitations to be aware of when considering the role of spirituality and healing and these issues underscore the need for education. Sloan, Bagiella and colleagues warn against linking spirituality and religion with health (Sloan, Bagiella, & Powell, 2001). They propose that asking patients about their spiritual or religious affiliation is

\(^1\) Arguments about this form of professional stealth are ongoing. It is argued that the push toward integrative medicine is merely a modern version of the same battleground (Hunter, 2005).
intrusive and may cause harm. Such actions, they argue, may cause a patient to feel ashamed, guilty, offended or even discriminated against. They suggest that some patients still feel that illness is a punishment for ‘moral failure’. A patient may feel that any spiritual or religious lapse on their part has contributed to their illness and view discussion with trepidation and/or hostility. Accordingly such questions may reinforce a negative mind state that could be deleterious to health. Delicacy, tact and good counselling skills are required – does a busy practitioner have the time and skill for such an interaction? Also they question if spiritual assessment may create two classes of patients, those who receive important spiritual and religious recognition and acknowledgement and those who don’t.

Spiritual assessment is considered a reasonable and useful tool to ascertain the spiritual/religious constructs which can inform a patient’s approach to their health. However, the issue of spiritual assessment is sensitive and contentious on many levels. While assessment tools have been developed to assist practitioners, the strategies for application require skill, knowledge of boundaries and appropriate models of behaviour. These are useful and practical tools that can be taught. Spiritual assessment is discussed in Appendix 7.

Another issue is that knowing that spirituality/religion are important in people’s lives doesn’t necessarily make it a given, good or easy thing to incorporate into professional practice. There are several areas of concern. For example practitioners, particularly in the biomedical model, are often working in a system that is controlled by strict economic parameters that confine their ambitions. They may wish to provide comprehensive care but find themselves unable to do so in the time allocated to them. The economic modeling of the health care system rewards technical efficiency, so a consultation that makes a diagnosis and recommends a treatment within a tight time frame means there may be time to do little more than prescribe medicines as judiciously as possible. The model does not allow much space to get to know the patient let alone delve into deeper more mysterious/less accessible aspects of disease.

Even if practitioners wanted to they may not feel it is appropriate, that it is their business or that they are trained adequately to deal with or understand the ramifications of any information they receive. There are boundary issues with pastoral care workers and the concern that invoking a more sensitive area of a person’s life may begin a discussion in which the practitioner may not feel equipped to participate. Scheurich (2003) argues that religion and spirituality belong in the same group as confidentiality, privacy and sexual boundaries
and that inquiring about a patient’s spirituality is not the same as validation or encouragement.

McKee and Chappel point out that cooperation between physicians and clergy is desirable, but may not occur or there may not necessarily be mechanisms to enable this interaction to happen (McKee & Chappel, 1992). It is more likely that there is a simple passing of the baton by way of referral. They add that physicians may neglect this area of patient health through personal discomfort, concern about inadvertently proselytising and ideological conflicts about medicine being a science and spirituality being something that is not (McKee & Chappel, 1992). Astrow and Puchalski state that ‘merely being a believing person does not qualify a clinician to dole out spiritual advice’ (Astrow & Puchalski, 2001 p.286). They point out the imbalance of power in the patient/practitioner relationship can invite confusion and spiritual/religious advocacy could be read as coercion. Puchalski and Larson (Puchalski & Larson, 1998) describe the situation as a power differential noting that practitioner and patient do not have an equal relationship. By virtue of their training practitioners hold power that may influence patients to follow their lead, especially if patients are in a crisis situation. This only affirms the need for training, to make sure that there is no conscious or unconscious proselytising or inappropriate persuasion. Rumbold probes the power relationship further questioning if the inclusion of spiritual care into the health care package acts to further undermine a patient’s (dwindling) sense of power (Rumbold, 2007). He argues that if it is perceived that a patient’s intensely personal convictions are now the domain of ‘experts’ that this may act to immobilise, depriving them of something heartfelt, rather than empowering them. The argument serves only to emphasis that the area can be very tricky and fraught with potential misunderstanding and further underlines the need for appropriate education in the field. McKee and Chappel affirm the need for practitioners to take into account a patient’s spiritual beliefs (McKee & Chappel, 1992).

Spirituality and religiosity can sometimes have a deleterious impact on health, reinforcing the idea that practitioners need to know the spiritual and religious affiliations of their patients. As Williams and Sternthal point out, religion can be used to justify hatred, violence and prejudice, and can be exclusive and dominating (Williams & Sternthal, 2007). If the religious or spiritual community has a strong and unyielding moral code, this can invoke guilt or rebellious behaviour that can play out in life in a way that has negative impact on health and wellbeing. Failure to conform to group expectations or prescribed codes of behaviour can
result in shame and reckless behaviour. Ostracism from a spiritual or religious group or community can cause illness, stress, self-harmful behaviours and depression. An extreme behaviour is when groups of believers partake in mass suicides or sexual practices which go against societal norms, such as polygamy and involving children/virgins in specific rituals.

Belief systems can impact on prescribed health care protocols. The Jehovah’s Witness community may resist interventions involving blood, according to their beliefs. Christian Scientists can advocate prayer over treatment, depending on their interpretation of their teachings. These beliefs, while valid for the community concerned, can cause stress if they run counter to health protocols deemed necessary by practitioners of the dominant health care model. Fadiman writes about the consequences when two different cultures (Hmong and USA) collide in their approach to epilepsy in a child. The story she tells describes the clash that occurs when constructs of health are opposed. One culture sees epilepsy as a spiritual illness and fears and resists the prescribed drug treatment. The other sees it as a neurological dysfunction and punishes the family when they do not cooperate with the dominant health care system. There is a lack of recognition of each other’s codes of caring, and the consequences are played out very unhappily on the child and in the family (Fadiman 1998).

As a story it is illustrative of the strong connection for some, between their health and their spiritual convictions.

If a patient belongs to a spiritual or religious community that has strict dietary/physical practices, then this is important and relevant information. At all times the practitioner needs to know what spiritual/religious beliefs are being employed that shape the worldview of the patient. For example, if people are avoiding all animal food as part of their belief system, then this can have both positive and negative impact on overall health and affect their recovery from different conditions.

Gundersen points out the possibility of guilt as a factor in a person’s health: they may see their condition as a punishment, that they have been ‘insufficiently faithful’ (Gundersen, 2000). Religious doubts and fear can cause depression and morbid thoughts about self-worth and the value of living. Patients may feel shamed or condemned to eternal damnation through some perceived lapse in their moral code and the consequent guilt and panic can have a negative impact. Expulsion from a religious community can cause stress and harm and the concept of sin can bring patients to read illness as righteous punishment. There has been research between religious attendance and weight. The data are still inconclusive as questions
are raised about socio-demographic and health variables as contributors to the condition (Williams & Sternthal, 2007), however, the research speaks to the complexity of patient health presentation.

Patients with strongly held spiritual and religious beliefs may take counselling and advice more readily from their church community than from their health care provider and it may be difficult to discern between the interpreted views of the chaplain/spiritual leader and the basic tenets of the spiritual/religious code (Astrow & Puchalski, 2001 p.286). For example in a conservative Jewish (Hassidic) community there may be pressure to have a large family that can cause stress if the family is unable to accomplish this or there are health risks involved in repeated pregnancies. Similarly in the Catholic community if the family believes contraception is a sin the consequences on a marriage of possible compromised health of the mother can cause mental/emotional health strains that manifest in poor health, depression, stress and other factors of poor health.

These concerns are all interlinked with the need for a clear and practical education for naturopaths on how to address and manage this aspect of health. There are times when spiritual concerns mean that the practitioner will need to call upon the resources of a pastoral care team (if available and appropriate) and ask them to play a more active role. The signals could include issues such as when there is a conflict between the personal beliefs of the practitioner and those of the patient, when there are visible signs of spiritual distress or the patient has asked for specific help beyond the scope of the practitioner/patient relationship, when practitioners feels out of their depth, when there is a perceived need for community support, when the family seems to be suffering alongside the patient and the care team need to pull in more resources. Ability to recognise these signals can be part of an education process. Religiousness and spirituality comes in all shapes and sizes and vary from individual to individual in strength and commitment. When we consider the active participation of the general public with naturopathy it seems reasonable to conclude that practitioners be equipped to locate the patient and their spiritual/religious context and the degree to which it impacts on their health and their coping mechanisms.
Concluding remarks

This chapter looked at definitions of religion and spirituality, research on the relationship between spirituality, religion and health and associated issues that may present in practice. The chapter illustrated that paying attention to the spiritual side of health is central to the work of the naturopath who is working in the holistic framework which respects an integration of mind, body and spirit as fundamental to good health. While both spirituality and religion are constructs that are important for a naturopath to acknowledge in their patients, the real focus in practice is the way it impacts on health. As Hilbers et al. note the issue is not if someone is spiritual or religious but how they express their commitment (Hilbers, Haynes, Kivikko, & Ratnavyuha, 2007).

This chapter demonstrated the extensive and intricate relationship between spirituality and health that has been marginalised as the biomedical model of health care in the West has become increasingly technologised and pathology focussed. The resurgence of interest in spirituality as a component of health, evidenced by the increase in research, is demonstrative of patient desire to have a relationship with their practitioner that extends beyond the technical. Renewed interest is reflective of a society burdened by materialism and alienated, to some extent, by an over-efficient technology in modern healing approach.

Spirituality belongs in the healing paradigm; as Swinton puts it, ‘the story of illness can never be narrated by the disciplines of science and medicine alone’ (Swinton, 2006 p.921). A patient’s spiritual convictions are a determinant of health and an established factor in recovery, wellbeing and longevity. The recognition of the extent of the role it plays in the health is influenced by the philosophic mores of the dominant culture. In current practice in the modern West, the technologically based ‘blindness’ of biomedicine has created an environment described as ‘spiritual hunger and this has ‘rebooted’ the relationship, stimulating research into the indefinable aspect of healing that we call the spirit, the one that won’t go away (Moore, 1992). The spiritual component of health care is central to the work of the naturopath.
Chapter 5
Methodology

The methodological approach taken to the collection and interpretation of empirical data for this investigation is inductive in nature and focused on making sense of documentary and interview data though the development of emergent themes. The approach, which is referred to by Lincoln and Guba as *naturalistic enquiry*, provides a suitable basis for seeking to understand the role and importance of spirituality in the training of naturopaths in Australia (Lincoln & Guba, 1985). This chapter presents details of the design and method of the empirical investigation. It addresses particularly the nature of qualitative enquiry, details of the sites for the investigation, the ways in which relevant documentary and interview data were collected and analysed, the importance of considerations related to trustworthiness and reliability, and the format for reporting the data in the three chapters that follow.

Naturalistic enquiry

The approach to the collection and interpretation of data for this investigation is *constructivist* in epistemology, *interpretivist* in theoretical perspective and *ethnographic* in methodology. It is an approach that draws upon a tradition of qualitative research as documented in the writings of Glaser and Strauss (1967), Denzin and Lincoln (2000 ), Patton (1980, 1990, 2002), Berg (1989), May (2002), Hammersley (2000), and Strauss and Corbin (1999). Consistent with a constructivist epistemology, its focus is upon the ‘world of lived reality and situation-specific meanings’ (Schwandt, 1994 p.118) or, in other words, its seeks to provide an understanding of the role of spirituality in naturopathy education that is based upon insights obtained about how those involved with naturopathic education perceive and apply this concept in their teaching and learning. Consistent with an interpretivist perspective, it accepts that it is the investigator who ultimately gives meaning to the social phenomenon under investigation but only after having become immersed in the meanings given to the phenomenon by those most directly affected by it. The investigator is, therefore, the instrument through which emergent themes from the meanings created by others are
articulated. In articulating these themes, the interpretivist investigator must be acutely aware that: ‘human knowledge claims are active constructions of meaning and, therefore, always relative to the unique interaction between the inquirer and the particular context in which the enquiry was conducted’ (May, 2002, p.264). Consistent with an ethnographic methodology, it ‘involves first-hand intensive study of the features of a given culture and the patterns in those features’ (Gall, et al., 1996,p.607) with a view to discovering cultural patterns in human behaviour, describing culture as its members see it, and explaining a culture within the context of its natural setting (Gall, et al., 1996). According to Geertz, the ethnographer ‘inscribes social discourse; he writes it down’ (Geertz, 1973, p.19).

The elements of constructivism, interpretivism and ethnography are combined in Lincoln and Guba’s conception of naturalistic enquiry. The key features of this conception are as follows: First the enquiry must be conducted in the natural setting of the phenomena under investigation (Lincoln & Guba, 1985). In the present investigation, this feature implies that the place of spirituality in naturopathic education must be examined in the particular educational settings in which naturopathy is taught. Second, a human is the instrument for the enquiry. This feature of naturalistic enquiry poses potential risks in terms of considerations of validity and reliability, but, as Lincoln and Guba observe, only a human as instrument has the capacity to adapt and respond appropriately to the indeterminate conditions of field research involving other human beings. In the present investigation, however, this feature implies a need for strict adherence to requirements for assuring trustworthiness and reliability in qualitative research. Third, naturalistic enquiry builds on being able to tap into ‘tacit’ knowledge. Tacit knowledge is the kind of knowledge that is accumulated as a consequence of experience in a particular cultural setting. The human-as-instrument is sensitive to this kind of knowledge, which is often foundational to the insights and hypotheses that eventually emanate from naturalistic enquiry. In the present investigation, the researcher shared with the informants a depth of understanding of the culture of naturopathic education, thus enabling tacit knowledge to be identified, evaluated for its relevance and then documented. Fourth, certain methods of data collection are especially conducive to naturalistic enquiry. These methods include interviews, observations and documentary analysis – all of which are employed in the present investigation. Fifth, naturalistic enquiry generally employs purposive sampling, as opposed to representative sampling, because its focus is on maximising information rather than enabling generalisation. In fact, one of the guiding principles of naturalistic enquiry is that it should continue up until the point of data redundancy regarding
the phenomenon under investigation, that is, cases are selected because of their potential to provide rich data, and more cases are selected up until a point where emergent themes have become clearly established and there is no need to explore additional data sources. Sixth, naturalistic enquiry proceeds on the basis of inductive processes of data analysis, that is, the focus is on ‘making sense’ of the data through the development of an understanding of it, usually expressed in the form of conjectures or emergent themes (Lincoln & Guba, 1985, p.202). In this regard, coding the data, as in content analysis, is usually employed as a basis for identifying categories and themes. Finally, naturalistic enquiry is nearly always guided by an intention to develop a conceptual understanding based on an appreciation of the immediate data (as opposed to collecting data in the light of an existing conceptual understanding) and it generally proceeds on the basis that a research design may be changed in response to new insights or in the light of issues and claims raised by informants. Naturalistic enquiry is comparable in style to investigative journalism, where every new circumstance in the process of assembling the story may open up completely new lines of enquiry.

Sites for the investigation

Data for the investigation were collected at five sites. These sites were selected because of their likelihood to contributing to the richness of the data collected as the most established providers of naturopathic training in Australia. As reported in Chapter 2, naturopathy is taught in a wide variety of training settings in Australia. A decision was taken to restrict consideration of these settings to the primary institutions awarding advanced diplomas or undergraduate degrees in the area. A total of five institutions across Australia met this criterion and these were selected as providing a suitable spread of settings for the purposes of the investigation. These institutions were all located on the east coast of Australia.

The first setting selected was Southern Cross University (SCU) at Lismore in the northern coastal region of New South Wales. Southern Cross University, which was established in 1994, provides programs of study across fields that include Arts, Business, Health, Education, Law, Science and Social Sciences. It is a publicly funded, self-accrediting institution that

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15 Within the Australian Qualifications Framework, an advanced diploma award is a post-secondary qualification usually obtained following two or three years of full-time study or equivalent part-time study, while an undergraduate degree is a post-secondary qualification usually obtained following either three or four years of full-time study or equivalent part-time study. In natural medicine, an advanced diploma generally requires three years of full-time study (or equivalent part-time), and a bachelor’s degree generally requires three to five years of full-time study (or equivalent part-time).
awards degrees and diplomas up to and including PhD level. It currently enrols 15,000 students, of whom approximately 250 are enrolled in the four year Bachelor of Naturopathy (BNat) program. The BNat program was established in 1995. Annual intakes to the program during the late 1990s averaged between 80 to 100 students. More recently, with increased competition from other providers, annual intakes have declined to an average of about 60 students. Continuation of this program is currently (2009) under review because enrolment numbers have been dropping, making the course financially unsustainable in its present form. Consideration is being given to subsuming the course within a more general Bachelor of Clinical Studies program, which would also allow for the completion of majors in other modalities, including osteopathy.16

Data collection then continued at the Nature Care College (NCC) of Naturopathic Studies in Sydney. The college is a privately-owned institution and delivers a range of programs at the certificate, diploma, advanced diploma and degree levels. Its certificate-level programs are in the general interest areas of yoga, massage, beauty therapy and life studies. Its diploma, advanced diploma and degree programs are in the areas of naturopathy, homoeopathy and herbal medicine. The college was established in 1973 and has a current enrolment of almost 3,000 students (mainly part-time students, enrolled in short courses). Between 2005 and 2008, this college offered a bachelor-degree program in naturopathy, which was accredited by the Vocational Education and Training Accreditation Board (VETAB). Recently, however, the college has ceased to offer this program and is, instead, concentrating on the provision of sub-degree programs.

The third setting for data collection was the Australasian College of Natural Therapies (ACNT), also located in Sydney. The privately-owned college has a current enrolment of about 2,000 students (mainly part-time, in short courses). It was established in 1982 and it offers a comparable set of programs to those delivered by the NCC. It has a three-year full-time advanced diploma program in naturopathy, from which graduates may seek to progress to a Bachelor of Health Science (Complementary Medicine) program offered by Charles Sturt University with provision for advanced standing. They may complete the Bachelor of Health Science program in one year of full-time study. Details of annual intakes to the advanced diploma program, and of the number of graduates from this program who transfer with

16 A major is a system whereby a student does a base course then chooses a strand or number of courses that direct their learning in a significant direction e.g. they do a clinical science degree with all osteopathy subjects so they have ‘majored’ in osteopathy.
advanced standing to the degree program offered by Charles Sturt University, are not made publicly available as they are regarded as being commercially sensitive. It is estimated though that as many as 100 students commence the advanced diploma program, either full-time or part-time, each year.

The fourth setting was the Endeavour College, formerly known as Australian College of Natural Medicine (ACNM), at its Brisbane campus. Established in 1975, this privately-owned college has six campuses across Australia: in Brisbane, the Gold Coast, Melbourne, Sydney, Adelaide and Perth, and has a large student enrolment (again mainly part-time, in short courses). It is the largest provider of natural medicine and related courses in Australia. It offers four-year degree-level programs in acupuncture, naturopathy, Western herbal Medicine, homoeopathy, musculoskeletal therapy and nutrition, as well as many additional general interest and lower-level award programs. Its Bachelor of Naturopathy program may be completed full-time or part-time. Details of annual intakes to the program are not made publicly available and are regarded as being commercially sensitive – but it is estimated that as many as 200 students commence the program on a full-time or part-time basis each year throughout the college’s six campuses.

Finally, data collection involved the Southern School of Natural Therapies (SSNT), located in Melbourne. This not-for-profit institution was founded in 1961. It offers the Bachelor of Naturopathy as a four-year (if full-time) program that has an average annual intake of about 50 students. The school has a total student enrolment of about 800 students, mainly completing short courses part-time.

Setting up the data collection involved three steps, following approval from SCU ethics committee: contacting the site institution and arranging access, setting up the meetings and then doing individual and focus group interviews. For the investigation, a total of twenty-five individual interviews with students and lecturers were conducted. These were supplemented by two focus group interviews: one involving seven students and one involving ten students.

The targets for participation were lecturers and fourth-year students. The investigation targeted these groups for two reasons. Firstly, senior student participants are still ‘fresh’ enough in their education to speak comprehensively and vividly about their educational experiences. Their viewpoints offered a good window into the process from the inside.
Interviewing them seemed likely to produce valuable information about what they thought they would learn, what they did learn and what they thought naturopathy was all about. Secondly, lecturers were invited to contribute their viewpoints on the spirituality as component of education.

The researcher had to obtain permission from ‘gatekeepers’ to conduct interviews and focus groups. These gatekeepers were the principals of the private colleges and the head of department at the university. It was at this point that a major obstacle to obtaining data began to appear. Three private colleges restricted access. Nature Care College (NC) refused access to its students on the grounds of being ‘worried about competition’. Despite explanation regarding the nature of the research and the potential benefits to the college, the owners (business people with no training in natural medicine) were suspicious and unbending, viewing research as a possible threat to the success of their business. Interviews at the college could not, therefore, proceed. This attitude could indicate how the educational direction of a college may change when commercial interests become paramount. The same experience was encountered at Endeavour (ACNM), with one interview with a senior manager being the only interview allowed. Southern School of Natural Therapies (SSNT) restricted access and one telephone interview was recorded with a senior staffer. Interviews and focus groups proceeded at Australasian College of Natural Therapies (ACNT) and at Southern Cross University (SCU).

Interviews were confined, therefore, to lecturers and students at SCU, ACNT and Endeavour. The interviews were conducted in Sydney, Lismore and Brisbane. The interviews were held in faculty meeting rooms, offices and open spaces (e.g. a garden setting), lunch rooms and lounges. Focus group interviews were conducted in Sydney at a natural therapies clinic and in Lismore in a student common room.

**Documentary data**

Handbooks and prospectuses were gathered from all five institutions; most information is no longer available in hard copy but can be accessed online at the college websites. Unit statements and course outlines for units of study that presented the philosophy of natural medicine were sought out. These units had titles such as ‘Introduction to Naturopathy’, ‘Philosophical Foundations’, ‘Naturopathic Foundations’, or similar names. There were no
units of study found that were devoted exclusively to spirituality and health, however it was considered that this topic would be represented in units of study relating to naturopathic philosophy. Websites for all five institutions were examined for statements about spirituality and health, and for references to the philosophical underpinnings of naturopathy. The course or unit outlines were assessed for content relating to philosophy and to the inclusion of spirituality. Textual analysis looked at unit objectives; unit assessment tasks and time allocations to content areas related to the philosophy of natural medicine and naturopathy.

The search process had limitations in that the private colleges are run as ‘for-profit’ businesses and so information beyond what is available in the public domain is considered commercially sensitive and was consequently not readily available. Also the industry is ever-changing, with institutions being bought and sold, and with name changes occurring with increasing frequency. In the process, documentation becomes out-of-date quickly and, in some cases, it was unclear as to what the current curriculum was.

**Interview and observational data**

The investigation required the collection of both interview and observational data. Students and lecturers from across the five sites for the investigation were the key informants. As indicated earlier, access to informants at three of the sites were minimised or blocked (NC, blocked, SSNT, minimised, Endeavour, minimised). Semi-structured interviews were conducted with informants at the remaining two sites (SCU, ACNT). The purpose of these interviews was to elicit information relevant to the central questions of the investigation. Throughout the process, the settings within which the participants worked or studied were observed at length for the purposes of understanding the nature of the social interactions and to discern prevailing attitudes regarding curriculum priorities in regards to the placement of spirituality in naturopathic education. Individual and focus group interviews were organised to fit in with the availability of the participants.
The interview schedule

The first question in the interview schedule was: *what do you see as being the philosophical foundations of natural medicine?* This opening question was intended to elicit baseline information regarding the understandings of the philosophical constructs of natural medicine. While it may seem a very basic question, it needed to be asked to locate the participants in terms of their belief structure and their approach to natural medicine. The second question was: *how do you see these foundations reflected in the curriculum offered by your school/college?* In order to talk about spirituality it was important to know if informants had had a solid introduction into the philosophy of natural medicine. The question sought to discover informant confidence with and commitment to their training and the extent to which it had ‘grounded’ them in their philosophical development. The next question led the informants more directly into the issues of spirituality by asking: *what does the notion of spirituality mean to you in the context of natural medicine education?* This question aimed to elicit basic understandings of the key philosophical component of spirituality and the way that they saw it located in natural medicine. It aimed to open up the subject more for reflection and consideration. The fourth question was: *what manifestations of this notion would you identify in the curriculum offered by your school/college?* The question was designed to get informants to talk about their training and consider where and how spirituality had been taught. This could lead to information about other ways of learning about spirituality, such as tacit learning as well as direct instructions. The final question was: *how important is it, in your view, that students of natural medicine be provided with structured opportunities for the development of philosophical knowledge and growth?* The question aimed to find out the level of importance the informants attached to the concept of spirituality in the context of naturopathy and whether they felt it should be integrated more actively into naturopathy education. The questions asked were meant also to act as springboards for reflection and more extended responses.

Individual interviews

Permission was given to interview students and lecturers, however once permission was obtained; it was not always smooth sailing. Some participants were wary, needing confirmation that their comments were confidential and they would not be indentified if they spoke about program structure and design. Students, in particular, needed to know that their
comments would not reach lecturers or administrators within the institution with which they were involved as they were concerned it would impact on their treatment as members of the educational community. At all times confidentiality was assured verbally and in writing and all records were coded to keep this commitment.

This need for confidentiality was a common concern that emerged in the introductory phase of the interviews and to a lesser extent in the focus groups. Many students were very careful to ensure that they were speaking privately and that their words would not reach the administration of their institution, indicating a cautious relationship with the administration and officeholders of their institution. The need for safety was strong and the atmosphere would remain guarded until they had received that assurance. A reluctance to speak openly about their experience could be interpreted in a number of ways but was consistent enough to indicate a lack of trust between the organisation and the students. This may not be particular to natural medicine. Students generally view administrations as gatekeepers in that they hold the keys to successful and untroubled attainment of graduation. Although the market ethos that governs education has changed the power relationship and students are much more empowered than they used to be, there is still the knowledge that the staff will assess their work and in that regard, it is wise not to antagonise those who mark you. No matter how many grand statements are made about lecturer integrity and fairness and transparency, students remain fully aware that staff and administrations have great influence on their successful passage. Accordingly, students wanted to be able to talk about their courses knowing they weren’t going to be ‘dubbed in’ if they complained, criticised or made any kind of disparaging comments. Lecturers, in private colleges more than the universities, expressed a similar need as they had concerns about ongoing employment. They went to great lengths to ensure that they talked off-campus, that their comments would go no further than the research document and that they could not be identified.

All individual interviews with students and members of staff were conducted in a manner consistent with that recommended for ethnographic interviews by Spradley (1979). Thus, the interviews were conducted in as natural a manner as possible, the approach was friendly, striving to establish a rapport. In the interviews, the researcher tried to remain neutral and create an atmosphere of trust and confidence so that participants could relax and speak about the issues raised. The integrity of the interview relied on neutrality, tact and respect so that the validity of the interviewees’ experience could be revealed as honestly as possible.
Ethnographic interviews require that the informants feel familiar with the setting and ‘safe’ in reporting their experiences (Hammersley & Atkinson 1995, p.101). To this end, the interviews with individual informants were conducted in whatever location (classrooms, clinics or outdoor settings) suited each individual. The interviewer had to practice active listening, and sit in silence as people struggled to express their thoughts. No matter how strong the temptation was to finish a sentence or interpret a response, the interviewer had to sit back and listen with sincerity, curiosity and genuine interest in what the interviewees were trying to say. As a technique it helped clarify the understanding of responses and it provided reassurance. The aim was to encourage deep reflection. Participants were asked at the end of an interview if there was anything they wanted to add. The purpose of this was to encourage confidence in the research and allow for extended discussion if required.

It was important in the interviews to enable the participants to feel ‘heard’. There needed to be a significant level of safety in disclosure that would overcome any reservations about the taping of the session. Assurances about the purposes of the tapes (to ensure accuracy) and secure storage of them were necessary. Privacy of location was important and all interviews were conducted in a place where the participants felt they could speak confidentially and without being overheard. Notes were taken after each interview. These recorded impressions to describe the context of collection (part of the immersive process) and any other insights, such as body language, relevant to the situation. Such notes were made immediately after each interview, sometimes sitting in the car outside the interview site. These notes were also stored in a safe place.

Interviewees were reassured that the research being undertaken had received formal approval by Southern Cross University (SCU). To this end, they were each sent a summary of the purpose and processes intended to be applied in the research together with details of approval of the research by the SCU Ethics Committee.

The technical structures supporting the interviews and focus group were as follows. Permission was given by the college/institution/authority and students were invited to participate through notice from their lecturer/clinic supervisors. Participants were guaranteed anonymity throughout the process and all information was maintained and stored according to SCU Ethics Committee guidelines. Should a participant have indicated at any time their wish to withdraw their interview, or any part of it, or from the investigation entirely, then this
happened. Notes were taken immediately after each interview or focus group. At each individual interview and focus group the project was briefly outlined and the consent documentation explained and signed by the participants. The information sheet and the definition of spirituality were handed out (See Appendices 2,3 & 4). The allocated time for each interview focus group was 40 minutes and these were taped. The questions are attached in the interview schedule (see Appendix 1). With open-ended questions, however, allowance had to be made for the participants to ‘respond in their own terms’ (Patton 1990, p.295).

Individual interviews with students were conducted in two locations. The first of these was the campus of Southern Cross University. The location provided a very pleasant venue for the individual interviews with students. The campus is leafy; the weather is generally fine; matters such as parking and accessibility are not a problem; and there was an atmosphere of scholarly openness. Eight students were interviewed in this setting. Some were happy to be interviewed in a staff researcher’s office. Others preferred the peacefulness of the university’s herb garden. The students concerned had all responded to an invitation given to final-year students to volunteer to contribute to the investigation. They expressed a keenness to be interviewed and were forthcoming with their views in response to all of the questions asked. The students were mixed in terms of their age. The oldest was forty-two years of age and the youngest was twenty-four. Most of the students were female. It was not unusual for the interviewees to be studying naturopathy as a second career, selected because of their commitment to the value of healing.

Interviews with seven university lecturers were conducted in their own offices. These rooms often had plants, many books on herbal medicine, nutrition, anatomy and physiology and related health sciences. The images in the offices were often of the natural environment and there were on occasion, posters of philosophical and inspirational sayings. The lecturers were warm, willing and responsive to the focus of the research and appeared keen to put their views forward. All were supportive of the concept of spirituality and key component of holistic medicine and all had specific ideas about its role and placement in the program.

An individual interview was conducted at ACNT with a senior member of staff. The formal office setting offered very little by way of personal detail; there were no photos of family or other personalising artefacts. It was clearly an administrative centre and held up-to-the-minute computer technology, leather seats and business-like desktop artefacts. The individual
interviewee was friendly and helpful although appeared to be somewhat reserved. It felt as if she could discuss the philosophical construct of naturopathy and spirituality but was cautious when it came to identifying any possible weaknesses in the curriculum with which she was involved.

Nature Care (NC) college declined access to students and staff, however three lecturers who had taught at the college offered to see the researcher independently. They wanted the opportunity to speak about what they perceived as important issues for naturopathic training. These interviews were conducted in private homes. These were places with children, pets and partners in the background abounding in family atmosphere. The atmosphere was friendly and informal, although confidentiality was an important issue.

An individual interview with a senior management staffer at Endeavour College (ACNM) in Brisbane was conducted in the college cafeteria. In that atmosphere it was hard to get anything more than a semi formal sense of relationship. The interview remained on courteous and restrained lines. The college later declined access to any staff or students.

A phone interview was conducted with a lecturer from Southern School of Natural Therapies (SSSNT) as the college was geographically distant. The tone was friendly and helpful, although it was hard to achieve a sense of connection.

Focus group interviews

A focus group was used to reach more people and encourage a fuller conversation and access a wider range of views. The focus groups (one at SCU and one at a private college, ACNT) were created through invitations extended to all final-year students. The ‘conversation’ between the participants was a source of rich data as the group dynamic took the topic in a number of directions as participants affirmed or disagreed with each other. The interaction of the group can bring forth insights termed ‘group effect’ whereby the dynamic of the group, assisted by a skilled moderator, can reveal more data and insight through their discussion (Carey & Smith, 1994). The researcher initiated the discussion with trigger questions from the interview schedule and facilitated the flow of exchange between participants. It was considered important to direct questions to quieter members of the group if any one person or
persons appeared to be dominating. The combination of an informal setting, open-ended questions, and the presence of others actively promoted rich data through relaxed interchange.

The focus group at the SCU was conducted in the tutorial room in the teaching clinic. The clinic is set adjacent to a small park and the rooms are peaceful. There are trees evident from the windows. The teaching room itself has lots of windows allowing plenty of natural light. There are three computers and multimedia equipment as well as a small library of natural medicine reference texts, a white board and a central table with chairs around set up for group discussion. There are desks and study areas set up under the windows. The atmosphere is of a comfortable yet professional learning space. In that regard it was ideal for a focus group as it was a good size for a discussion and the atmosphere was slightly relaxed, yet still of a place for learning. Students arrived in groups and fell quickly into places around the table, reading the consent and information forms. They were clearly comfortable with the space and with each other.

The focus group at ACNT in Sydney was conducted in the lunchroom of the teaching clinic. The space had a sink and fridge at one end where students could store their lunches and make tea and other hot drinks. There was a table in the middle with a series of chairs alongside. The clinic itself is set on a busy city road and traffic noise drifted up. The area showed signs of lots of use with bags, books and items of clothing around, a crowded noticeboard and places and cups on the bench by the sink. Students arrived for the focus group and settled in, reading the consent and information forms. The group was largely female and they appeared to be well known to each other. While the focus group was conducted other students drifted in and out getting their lunch, making drinks, picking up bags and so forth. The atmosphere was noisy and busy. The focus group, which was comprised of students, was not reserved and the participants spoke boldly, until a senior staffer joined the group. Then they held back and let the staffer dominate. Up until that stage they were forthright and outspoken and held strong views about how the college should be run and what could be done to improve their teaching program.
Observations

The final stage was the collection of observational data by attendance, where possible, at introductory philosophy lectures in selected situations. Lectures were attended at the university site and at two private colleges. These were the introductory lectures in the naturopathy programs and had names such as Naturopathic Foundations/Introduction to Naturopathy/Naturopathic Philosophy. Notes were taken and lecture material was collected and analysed. The researcher sat in the lectures at the back of the class and followed the lectures as unobtrusively as possible, looking for the following points: the onscreen PowerPoint notes, the presentation, handouts, whether or not there was room for discussion, the teaching style and lecture content as well the engagement of the students. The researcher also tried to soak up the atmosphere as a way of ‘sinking’ into the training culture. The data gathered was in the form of observational notes, which were collected, dated and filed according to institution. Impressions were recorded during and after each lecture while they were still fresh. A coding system was implemented following Spradley (1979) whereby through semantic relationship and taxonomic analysis to pick up themes in the lectures and discussions. These themes were then cross-referenced with the identified themes from the interviews and focus groups.

Coding

The fieldwork data collected in the interviews and transcripts was indexed by labelling each interview according to the university/college and student/lecturer level. Participants were allocated a code according to the site, interview or focus group and occupation as follows:


*Focus groups:* University students UF 1–7. Private college students: PF 1–10

*Interviews:* University lecturers UL 1–7. Private college lecturers: PL 1–6

In the coding process participants were identified as student or lecturer. In the focus groups interviewees who had made particular comments were identified with a code. This was an important procedure as it allowed key informants to be tracked for member checking purposes. The drawing out of emergent themes was done using open coding system (Strauss & Corbin, 1990) whereby similarities in comments made by participants were grouped
together. A taxonomic analysis was used to identify words in the emergent themes so they could be identified across the groupings. Subsets of themes were identified, for example, the mentioning of homeopathy, the belief in the superiority of naturopathy over biomedicine, the confusion about spirituality and its application in practice. Colour coding was used. Each of these was given a different colour using highlighters on the transcripts (e.g. purple for philosophy of naturopathy, red for science emphasis) so that it would be evident when it came up in other places. The coding allowed the researcher to see the extent to which a theme was occurring, in what domain and to what extent. Spradley (1979) explains that in an ethnographic analysis we look for the relationship between the domains and the whole cultural scene; we break it down in order to understand the picture better. That way questions could be asked such as: was a certain theme more prominent in the private colleges or did the university students talk more about science overload?

**Data analysis**

The coding and consequent content analysis allowed themes to develop. Sim and Wright refer to this category formation as a process of summarising the data by identifying the similarities and differences within them (Sim & Wright, 2000). The searching for commonalities allows themes to surface. The emergence of themes can be like the shape of a village emerging from the mist after a long slog through seemingly impenetrable fog. The initial influx of data can be overwhelming and daunting: a pile of tapes, a stack of transcripts. But the process of coding enables the data to broken down into manageable chunks and these chunks are easier to examine for themes that are repeated. The repetition of a theme is an indication of a story that is significant, albeit in different forms, in the research. These themes are the signposts the researcher seeks, the ones that lead to the village slowly taking form in the mist. In reporting the data in later chapters a cross-referencing system is employed whereby students from the university are labelled US, interviews with lecturers at the university site a labelled UL. Interviews with students from the private college sites are labelled PS, and interviews with lecturers from private colleges are labelled PL. Focus group interviews from the university are labelled UF, and focus group interviews with students from the private college site are labelled PF.
As Spradley (1979) explains, the writing of an ethnography is a translation, to explain the culture of education in natural medicine, we must understand the particular. The information collected from the interviews, focus groups, observations and documentary analysis was devolved into domains, searched for taxonomic analysis and then coded into themes. The themes were identified through colour coding for visual identification that was then recorded on a grid for prominence and repetition.

In this way patterns in the cultural landscape could be recognised and identified when and where they occurred.

**Trustworthiness and reliability**

Trustworthiness and reliability in qualitative enquiry refer to the extent to which an enquiry’s findings are, in fact, ‘worth paying attention to’ (Lincoln & Guba, 1985, p.290). The counterpart of trustworthiness in positivist research is validity. Ethnography requires extreme care to ensure that the subjective nature of the data collection process does not result in subjectivity in the ways in which the data are analysed and interpreted. To this end, the ethnographic researcher must be highly sensitive to issues of rigour. Lincoln and Guba (1985) introduced the notion of trustworthiness in an attempt to place under one umbrella a range of considerations that affect the extent to which data generated by means of ethnographic research can, in fact, be trusted.

To achieve the goal of establishing trustworthiness, Patton suggests a number of strategies. These include *triangulation* (checking of data from different viewpoints), *prolonged engagement* (extended contact with participants), *peer debriefing* (working with a non-involved peer to gain perspective), and *member checks* (reflective feedback with participants regarding the researcher’s interpretation of what has been said). A combination of these can be employed to strengthen the research work (Patton, 2002).

Triangulation in the project involved the collection of data through interviews and focus groups, observation of the teaching context, and collection and analysis of curriculum documents. The aim of collecting data from multiple sources was to reduce ‘personalistic bias’ (Denzin, 1998) and to develop a richer understanding of the topic. By combining different data-gathering procedures, the researcher was better able to clarify and confirm
findings. For example, if students reported a minimum of time spent on philosophy, a check of the curriculum documents could verify whether or not this perception was likely to be true. Prolonged engagement with the topic occurred because of the extended period of data collection – during a six month period, the researcher engaged with the informants and became steeped in their learning environment. Where informants were able to add to the material provided through their individual interviews, they were encouraged to do so. Peer debriefing occurred through regular discussion with the doctoral supervisor, together with a process whereby a colleague whose interests lay outside of naturopathy would routinely listen in a critical way to accounts of how the actual data provided by informants were being interpreted by the researcher. Member checking occurred constantly during the data gathering: at the of each individual interview, for example, the main points were reported back to each of the informants, who then confirmed the accuracy of what had been documented; while with lecturer staff, follow-up discussions of what they meant by different points expressed in interviews, were conducted on a routine basis.

Concluding remarks

The methodological construct of ethnography was used to give a penetrative insight into the culture of training and education in natural medicine in Australia. The atmosphere, the conditions of research, the nature of the interviews and focus groups all contributed to giving a window into the lived experience of those participating in the education culture. Discussions with lecturers and students gave insight into the training experience. Ethical issues arose in that the participants displayed appropriate cautions about speaking about employers or assessors. The researcher was both bound to invite confidence and at the same time not contribute to any perceived prejudices or leanings. It is a conundrum in research – one needs to invite trust, but not intimacy.

The process of investigating the integration of spirituality into naturopathic education led to discussion about the philosophical foundations, as the two were inextricably linked. The research was limited in the number of places and schools to which it had access, however, the education community in natural medicine is small enough to allow for some generalisability. Also students move from institution to institution and there was within the interviews some reportage and comparisons made by students who had studied at more than one place. These comments informed the research. Within the interviews and focus groups there was positive
feedback. People welcomed the opportunity to air their views and ‘have a say’. It may be that there are few opportunities within the professional community for people to meet and talk. The research interviews and focus groups provided a place to give voice to their feelings about the nature and quality of education. The researcher was able, through the goodwill of the participants, to pursue the research and collect the data.

There emerged within the interviews and focus groups some themes that came up again and again indicating data redundancy. For example there seemed to be student confusion about the actual philosophical foundations of naturopathy and commonly it was described as a mode of practice (holistic, patient centred, lengthy consultation). Confusion about the role of spirituality also featured in the interviews.
Chapter 6

Examining the documentation

Course documents provided an important initial source of information concerning the place of spirituality in naturopathy programs across Australia. Though the richness of documentation available varied greatly, some important insights became evident when the documents that could be located were subjected to systematic analysis. This chapter reports on how the relevant documentary materials obtained from websites, course documents and unit statements was evaluated in terms of the quality of attention given to the role and importance of spirituality as foundation for the practice of naturopathy. The chapter also identifies key emergent themes relating to the context within which naturopathy students and their teachers engage with spirituality.

Southern Cross University

The website for the School of Health and Human Science (which is responsible for delivery of the Bachelor of Naturopathy program) at Southern Cross University is very ‘matter of fact’. It does not try to grab attention with photographs or images that relate to naturopathy. It is businesslike and formal. Regarding the Bachelor of Naturopathy program, the website states simply that the program contains:

Biomedical sciences with theoretical and clinical training in nutrition, phytotherapy (herbal medicine), tactile therapy and homoeopathy. A strong clinical focus enables students to develop a range of clinical skills, integrating theory and practice (Southern Cross University, 2009).

The emphasis on biomedical sciences is of note, together with the fact that naturopathy, as a field of studies, is not defined. Neither is there any statement about what naturopaths do, or what the practice of naturopathy requires in terms of personal and professional skills and
aptitudes. The website designers probably assumed that prospective students would already know this information.

There is a link from the website for the School to another website that contains details about each of the programs offered by the School. The website also presents images of students enrolled in the School. Notably, all of these images are of women. The midwife, nursing and occupational therapy images are of women in uniforms in clinical settings. The naturopathy image is of a young woman in a light summer top located in a garden and cutting what could be assumed to be a herb.

The website provides access to a full range of documents regarding the Bachelor of Naturopathy program. The program is described as requiring four years of full-time study, or part-time equivalent, and there is a link to pages that provide a brief description of each of the thirty-two units of study to be completed as part of the program. The program is structured in such a way that students, during their first two years of full-time study, spend most of their time concentrating on science subjects, including anatomy, physiology, chemistry and biochemistry. A copy of the course structure for the Bachelor of Naturopathy offered by Southern Cross University is presented in Appendix 10.

A unit entitled Naturopathic Foundations is taught in the first semester of the first year of the Bachelor of Naturopathy program. This unit seeks to introduce students to the philosophy of naturopathic practice. The unit description is as follows:

> Provides a comprehensive introduction to basic naturopathic principles and places the practice of naturopathy into its social, cultural and historical context. This unit will cover a broad range of topics including the philosophy of science, the social context of disease and health care delivery, the naturopathic approach to health care and emerging paradigms in health. (Southern Cross University, 2009).

It is of note that reference is made here to the philosophy of science, but not to the philosophy of naturopathy. Concepts such as holism, vitalism and spirituality are not referred to at all. While it is possible that these concepts are addressed, in this or other units (such as homeopathy) within the degree program, there is no explicit reference to them anywhere in the public documentation available from the website. Interestingly, a unit available to students as an elective study is entitled Cultural and Spiritual Wellbeing, but this unit is available from
a separate academic organisational entity, the School of Indigenous Peoples, at the University. The unit does specifically address spirituality and wellbeing. If students elect to take this unit they would be introduced to:

… concepts of spirituality as an integrating life force in a holistic paradigm. A cross-cultural perspective of spiritual practices, beliefs and expressions are explored, in particular, the role of others in resourcing and facilitating Spiritual Care. Students are expected to analyse their own concepts of spiritual wellbeing and develop a practical management plan for delivery of Spiritual Care to a specific group (Southern Cross University, 2009)

There is no course other than Naturopathic Foundations that directly address concepts of holism, vitalism and spirituality, according to the university list of unit statements. It may occur in the program as tacit or indirect learning.

Finally, it is of note that the Bachelor of Naturopathy at Southern Cross University has been comprehensively reviewed in 2000, and again in 2006, as part of the University’s cycle of academic program reviews. Panels comprised largely of people with relevant expertise from outside the university conduct these reviews. Students, members of staff and representatives of professional associations are routinely invited to make submissions to these panels. The review of the Bachelor of Naturopathy program that was conducted in 2000 recommended a significant restructure to the program. It emphasised the need for a less structured approach to program design. It recommended, for example, that students should have more opportunity to pursue elective studies in areas of personal interest, such as concerning the use of naturopathy in the context of caring for the elderly. The program review conducted in 2006 focused more in its recommendations on the need for there to be exit points from the Bachelor of Naturopathy program whereby students who elect to leave at the end of the first or the second years could obtain a credential in the form of, respectively, a Certificate of Health Science or a Diploma of Health Science. Though these awards were not intended to qualify students for professional practice, it was considered that they would provide a qualifications basis for future studies in the field. The program review conducted in 2006 also recommended the embedding of opportunities in the program for students to acquire competencies and perspectives advanced by the university as being desirable graduate attributes that should apply across all programs delivered by the university.
Nature Care College

Nature Care College is a large natural therapies college located in metropolitan Sydney. The College conducts a range of advanced diplomas in naturopathy, Western herbal medicine, homoeopathy and nutritional medicine. It also offers a great many general interest courses in areas that include yoga, hot stone massage, astrology, and Feng Shui (the art of placement, a study of how to arrange the physical environment to enhance wellbeing, prosperity and so forth). The College used to offer a degree-level program in naturopathy, but it now delivers an advanced diploma qualification only, with graduates from the program able to proceed directly to an upgrade degree at Charles Sturt University where, with further study of four units, they can attain a Bachelor of Health Science.

The website for Nature Care College is packed with information. It is also friendly in tone, engaging visually and very easily navigated. It includes enticements such as testimonials, recipes from the whole food café and gift suggestions from the emporium. It is full of encouraging words and phrases such as ‘follow your dream’ and ‘change your life with passion’. It is colourful and has lots of photos of happy (mainly female) students meditating, doing yoga or receiving massages. It also has visual images of herbs, a mortar and pestle, homoeopathic pillules, and so on. The website defines naturopathy as follows:

Naturopathy is both a science and a philosophy of healing with a tradition dating back many centuries. Like modern Western Medicine, the earliest roots lie with Hippocrates in 400 B.C. when Hippocratic practitioners looked at the body’s natural ability to heal itself and the healing powers of nature. Modern Naturopaths follow those same principles of “Nature-Cure”; they look for the cause of the disease and then use the most natural, non-toxic and least invasive therapy available. Naturopathic practitioners, working holistically with their clients, have a deep understanding that illness occurs on many levels. The aim of a Naturopath is to work with the client to gain a joint understanding as to why the illness occurred. From here an individualised treatment program is developed and holistic strategies put in place to encourage optimal health. (Nature Care College, 2009)

This statement refers to the vitalist underpinnings of naturopathy through its reference to the healing power of nature. It makes no reference to a spiritual component of health. It does, however, refer to holism as a clinical strategy.
On the website is a list of all the units taught within the advanced diploma program. The course has sixteen herbal medicine units, six homeopathy units and nine nutrition units. The first two years of the program contain units in science areas, including anatomy, physiology, chemistry and biochemistry. Interestingly, the program includes compulsory units in iridology and Bach flower remedies, neither of which areas is taught within the University program because they are areas that are considered to be scientifically unproven. A copy of the course structure for the Advanced Diploma in Naturopathy offered by Nature Care College is presented in Appendix 10.

Statements about the contents of each of the units in the program are also accessible from the website. The Introduction to Naturopathy is described as ‘inspiring’. It aims to provide an introduction to the philosophy and fundamental beliefs of naturopathy. It also addresses natural healing principles and the basic principles of holistic health. Both vitalism and holism are named as topics to be addressed, along with stress management, modalities of healing, detoxification and fasting. Spirituality is not explicitly identified anywhere. Two weeks of the twelve-week unit are devoted to student presentations in class.

Whether the college conducts reviews of curricula is unknown, however the process of accreditation with the Vocational Education Training and Accreditation Board (VETAB) requires scrutiny of the program by a panel of industry and professional experts. VETAB is the recognition authority that accredits vocational education and training courses in NSW. The accreditation is aligned with the Australian Quality Training Framework (AQTF), which operates nationally. A training institution needs to become a government registered training organisation (RTO) before they can issue qualifications and awards that are accredited and nationally recognised. These accredited qualifications are recognised under the Australian Qualifications Framework (AQF).

Australasian College of Natural Therapies

The Australasian College of Natural Therapies is a large Sydney-based natural therapies college offering a wide range of programs, including an advanced diploma program in naturopathy. Its website is extremely easy to navigate and contains many attractive images of fruit and vegetables, suggesting its ‘natural’ and ‘whole food’ commitments. The link to the advanced diploma program in naturopathy offers the following description of naturopathy:
Naturopathy is an umbrella term that encompasses many forms of complementary and natural medicine modalities. A Naturopath is a person who practices several of these forms or modalities and who also has a solid grounding in the medical sciences. The three major modalities within naturopathy are nutrition, homoeopathy and herbal medicine. ACNT trained Naturopaths are holistic practitioners who throughout this course will gain extensive knowledge in a variety of health sciences including chemistry, biochemistry, pathology, symptomatology, diagnosis and pharmacology. In addition to these health sciences a wide range of natural therapies subjects such as herbal medicine, nutrition, homoeopathy, iridology and other naturopathic modalities are also taught ensuring that ACNT graduates are highly regarded professionals. (Australasian College of Natural Therapies, 2009)

This description emphasises the science training for the students. It does not mention tactile therapies as a strand of naturopathy. Indeed it appears that students do only one unit of massage.

The outline for the Advanced Diploma of Naturopathy is found in Appendix 10. There is a long list of the units in the Advanced Diploma with hyperlinks to short descriptors. Notably this program includes two units of iridology along with one unit of Bach flower remedies. There appears to be only two units of anatomy and physiology, and two units of Symptomatology and Diagnosis. This is considerably less than the university program however it is not easy to make comparisons as teaching times are not equivalent and topics may be subsumed in other units. This program has a significant weighting towards homoeopathy (seven units), which is higher than the number of units in herbal medicine (six units). Nutrition is well represented with twelve units. The subject list is contained in Appendix 10.

The site contains a link to a unit called Philosophy of Complementary Medicine and Science and the course, which presumably introduces students to naturopathic philosophy, is described as covering the philosophical principles underpinning natural therapies. Starting from the foundation of Western and Eastern thought students will develop the understanding required to practice in natural medicine. Whether the course goes into holism, vitalism or discusses spirituality is not apparent.
Whether the college conducts course reviews is unknown however the process of accreditation with VETAB would have involved scrutiny of curricula by the external accrediting body.

**Endeavour College of Natural Health**

The Endeavour College of Natural Health (formerly Australian College of Natural Medicine) offers an undergraduate degree, the Bachelor of Health Science. It operates six campuses nationally in Australia (Brisbane, Gold Coast, Melbourne, Perth, Adelaide and Sydney). Recently Endeavour has expanded into the New Zealand natural medicine education market, buying colleges there. The website is comprehensive and easy to navigate, providing a definition of natural medicine on the home page. The definition states: ‘natural medicine is the practice of using medicine in its natural form, a principle known as the *vis medicatrix naturae*; “the healing power of nature” is the foundation of natural medicine philosophy and practice. Therapeutically, natural medicine stimulates and supports the self-healing processes, as opposed to treating symptoms or a particular disease.’ This definition refers to the importance of nature; the spiritual component of health is not mentioned. On the page specific to the Bachelor of Health Science (Naturopathy) it offers a fairly comprehensive description of naturopathy giving potential students some guidance to the philosophy and role of a naturopathic practitioner.

The origins of naturopathy can be traced to ancient Greece. Hippocrates, the 'Father of Modern Medicine' once described the human organism as a holistic combination of body, mind and spirit linked to the four elements of the natural world. This organism that is body, mind and spirit possesses an inherent capacity to generate self healing, given appropriate conditions. The role of the naturopathic clinician is to facilitate this process through teaching and providing a range of holistic medicines. The study of naturopathic discipline includes herbal medicine, diet and nutrition, flower essence therapy, nutritional supplementation, naturopathic diagnostic techniques including iris analysis, along with a general understanding of many other forms of therapy (Endeavour College of Natural Health, 2009)

There is a course overview in Appendix10 that lists the subject that are in the degree. It shows a timetable for study which indicates that the course is prescriptive, in that students appear to do three units a semester and two semesters a year. As noted previously it is difficult to
compare weightings of courses between institutions are they run on different schedules. Unit statements or descriptors of the units within the program are not available on the website.

Southern School of Natural Therapies

Southern School of Natural Therapies is based in Melbourne Victoria. It was established in 1961 by Alf Jacka and is a not-for-profit college. The website is more functional and less glamorous than those of the other colleges and is easy to navigate. It mentions the word spirit and offers this definition of naturopathy:

Naturopathy is a system of health care that combines a traditional approach based on thousands of years of history with a modern approach that incorporates recent advances in scientific research. Naturopathy today occupies an important and prominent role in the contemporary health-care system. Naturopaths view their profession as complementary to orthodox medicine rather than as an alternative to it, and, as such, regard themselves as an integral part of the broader system of health-care which the Australian public is fortunate enough to have at its disposal.

Health, from a naturopathic perspective, involves the capacity to maintain optimal order and function of the body (homeostasis) and is an outcome of a healthy mind, body, spirit and environment. Health can be impacted positively or negatively by mental, psychological and emotional factors, lifestyle, environment, diet and inherited genetic characteristics. In disease, normal metabolic function, tissue maintenance and repair processes are impaired and immunity and detoxification capacity is lowered, leading to functional disorders and chronic disease. (Southern School of Natural Therapies, 2009)

The outline of the Bachelor is presented in Appendix 10. Brief course descriptors are given through links. There is very little mention of holism, vitalism or spirituality.

Concluding remarks

There are observations to be made about the way the different institutions promote themselves. The university takes a spare, serious position and the website itself is somewhat clumsy to navigate. Those of the private colleges (NC, ACNT, Endeavour) act much more as promotional material in that they contain more images and are more colourful. The website of
SSNT is somewhere in between in that it is colourful and engaging, however its tone is more subdued. Images of women are common on the websites (natural medicine education is dominated by females). The students in the pictures are often laughing and smiling signifying that they are having a terrific time – unless of course they are meditating, doing yoga or having massages in which case they look serene. The photographs generally contain material such as attractive herbal material or fruit (signifying nature), microscopes and laboratory coats (signifying science) and smiling healthy looking young women (signifying enjoyable learning). Documentation regarding the role and importance of spirituality is almost nonexistent. Two of the websites mention the word spirit as part of the definition of naturopathy; however the allusion is carried no further. None of the course overviews contain a discrete unit in spirituality or spirituality and health. The philosophy units may or may not include reference to spirituality but it is not possible to tell the extent to which the subject is taught – if at all on any of the sites. The La Trobe report (McCabe, 2008) offered a comparison of training by including a comparison of hours, and this served to underline the inconsistency in training in naturopathy in Australia. In general the same subjects are covered but the depth and weighting varies a great deal. For a student viewing a naturopathy education provider website these differences are not necessarily apparent.
Chapter 7

Student experiences

Consideration of the experiences of naturopathy students with spirituality is critical to this investigation. The nature of the engagement, its intensity and its effects were all matters of central concern. This chapter presents an account of the experiences of students undertaking naturopathy training at three sites, one of which was a university and two of which were private colleges. A total of fourteen students were interviewed for the purposes of obtaining an in-depth understanding of their engagement with spirituality in the curriculum. Two focus group interview meetings involving a total of seventeen students were also held. Student experiences, details of information obtained from lecture and tutorial observations, as well as from prospectuses, unit outlines and course outlines are also reported where appropriate.

The University students

Individual interviews

Individual interviews were conducted with eight students from Southern Cross University. These students were selected for interview through open invitation issued in a lecture and at a tutorial. Senior (final-year) students were sought. Email addresses were gathered from those students who presented themselves as being willing to contribute and meeting times were subsequently agreed through email exchange. In the initial contact the students were assured of the ethical protocols and the confidentiality of the interview process. In the individual interviews, the students were given consent forms, a definition of religion and spirituality (see Appendix 4) before the interview commenced. They appeared eager to give voice to their feelings about naturopathy training and they appeared to be especially attracted to the possibility of being able to discuss the place of spirituality in the curriculum: *I have been dying to talk about this*, said one (US3). Another said: *We get so little about this and really, it’s an awesome part of naturopathy, at least I think so* (US2). As a researcher, it was good to feel the enthusiasm and openness of the students: *We really want to talk about this but there’s like no space or time for anything* (US3).
Five of the eight individual student interviews at Southern Cross University were conducted in a garden setting and three were held in the office of the researcher. The interviewees selected the location. At Southern Cross University there is a herb garden and a native plant garden situated around a lake. There are seats in shady spots near the lake as well as an outdoor learning centre. Students who elected to sit outdoors chose to sit in or near the herb garden. It appeared to be a place where they felt comfortable. Students would pick leaves from nearby herb plants (like peppermint or lemon balm) and crush them in their hands and smell them as they talked. The office of the researcher was located near the herb garden on the ground floor of one of the university buildings that looks out onto the playing oval. The office was also chosen as a place for interviews. In the garden, the interviews were conducted away from other people – indeed the gardens were mostly deserted apart from an occasional student cutting through on the way to classes. In the office the door was closed so as to ensure privacy and promote confidence in the confidentiality of the interview session.

The first question concerned student understanding of the basic concepts. The students were each asked: ‘what do you see as being the philosophical foundations of natural medicine?’ The interviewees provided a range of responses that edged around elucidation of the constructs of naturopathy. One student described the philosophical foundations of natural medicine in terms of a specific approach to therapeutic practice: *We don’t go against the grain; we use natural cures like herbs and fresh air* (US1). The student was perhaps trying to express a view that naturopathy as a practice works with the body’s self-healing mechanism. Another referred vaguely to the links between naturopathy and nature as a way of defining the practice, by stating: *When you’re a naturopath it’s kind of like you’re close to nature. I mean we can go to the herb garden and pick the herbs and make the teas or compresses that help the patient – how simple is that?* (US2). Another attempted to define natural medicine by contrasting the approach of the naturopath with that of the medical practitioner: *Doctors just treat something like the bladder, whereas we look at the whole person. I mean we want to understand what’s going on underneath a person and you can’t do that in the fifteen-minute consult can you? It’s so important to know as much as you can about a person before you start treating them* (US3). When asked to explain further what was meant by this contrast with medical practice, the student described the difference of professional approaches as follows: *We are more sensitive, I mean some doctors are good and that, but they don’t have the time to do what we do, I mean we really look into the whole person, not just the symptoms* (US3). Another student continued with this way of looking at themselves by saying: *We treat
people holistically. I guess you could say that, we go down the layers and think about what makes people sick. Doctors do a bit of that but the naturopath goes deeper (US6). This explanation referring to holism and the viewing of the patient as being many-layered was grasped at by another student as follows: The philosophical foundations are all to do with the way we think about a person. We see people in their entirety not just the presenting symptom. That’s what makes us different. Better (US8).

The interviewer encouraged each of the students to focus sharply on and describe the philosophical roots of naturopathy, rather than refer to signifying modes of practice, as it seemed important to find out if students could, in fact, articulate the philosophical foundations of natural medicine. This approach largely failed because the students continued to focus on differences in professional practice as the basis for giving expression to what was unique about naturopathy. One student said, for example, that: As naturopaths we treat people differently, we work with the vital force to regain health, we don’t interfere with the body’s natural healing process, like some drugs do; we don’t work against the body we work with it (US5). Another tried to pin down the philosophy by alluding to a style of healing practice that was more esoteric: We are true healers really. I mean we have to learn all that anatomy and stuff and that’s all good, really, but the truth is that the healing flows through us from our intent to heal, not just patch somebody up (US7). The student also stated confidently: It’s all about, first, do no harm. That’s our guiding motto (US7). Another commented: It’s really important to learn the foundations, as this is what we build our practice on (US5). When asked again about what the foundations actually were, the interviewee replied: Oh, you know, sunshine, fresh air, clean water, some hands-on and really trying to avoid using things that disrupt the vital force, like drugs (US5).

To the researcher it appeared as if the students had a sense of the philosophy but were confused when it came to actually articulating it. One student described the difficulty in identifying the philosophy by saying: I studied at a private college and then I transferred to the university and its better here. The teachers are so committed and passionate and that helps us, but I can’t say I know for sure what the philosophy is. All you learn in Nat Foundations is the history of naturopathy, which is good, I suppose. But when you ask me what the philosophy is, I can’t really tell you, I never had to define it (US1). The experience of confusion about the philosophical foundations of naturopathy was evidenced in a statement from another student: We learned an awful lot about German naturopaths of the nineteenth
century and not much else. It was stupid. Well, I suppose that’s good, but there’s got to be more than that, hasn’t there? (US2). When pressed further to define the philosophy, the same student commented: We learn principles and that – things like Vis Medicatrix Naturae. Is that the philosophy? (US2). Another student ventured: We did work on stress. Does that count? (US3).

Overall the students’ responses in the individual interviews, to the first question gave an impression of enthusiasm for naturopathy and its ‘special’ philosophy, however, they appeared to be uncertain about what it actually was. It came across as a jumble of ideas such as Vis Medicatrix Naturae, sunshine and fresh air and vitalism was mentioned. Mostly the students seemed to be on stronger ground when they offered comparisons to ‘regular’ doctors, talking about how the naturopath operated differently in practice (the implication was that they were more sensitive).

The interviewees were then each asked the second question from the interview schedule: ‘how do you see these foundations reflected in the curriculum offered by your school?’ The question resulted in some forthright responses: Some of the training is really pointless. It’s like they just want to cram the curriculum full of science and they don’t want to hear from the students. If it wasn’t for homoeopathy I could have forgotten why I was here (US1). Another student echoed this sentiment, stating: Homoeopathy taught us about the philosophy of healing (US3). Another expressed the view that the style of a lecturer was pivotal in terms of being able to understand the foundations of naturopathy: If you get a good lecturer then it comes through, otherwise the whole thing is pretty technical. That’s good, I suppose (US4). The sentiment that understanding the philosophy of naturopathy depended upon being able to interact with a committed lecturer, was echoed by another student: We learn about the philosophy a lot when we do phyto [herbal medicine] (US2). The researcher probed further, asking what was meant by that statement: I mean if you have a lecturer who believes in naturopathy and is really committed then we get that in the class, we really do (US2). One student confirmed the significance of lecturer ‘bias’: If you get the right lecturer, like a true blue naturopath, then you will get the real stuff. Otherwise we learn a lot of lecturer stuff. [sighs heavily] I suppose it’s relevant (US8). Another offered: I want to be really good naturopath who works deeply holistically and sympathetically, at least I think that’s what I want. I am not sure my training is going there. I seem to be learning a lot of chemistry. Even the nutrition is about chemistry; not food (US7).
The responses to the second question indicated student frustration with their program and a desire to learn more about the philosophy of healing. The line of questioning revealed a desire to learn more and their feeling that homoeopathy was the place to learn about spirituality in natural medicine. The way students pick up on lecturer’s personal position was also noticeable, with students identifying where a lecturer stood in relation to naturopathic philosophy.

The third question in the interview schedule was: ‘what does the notion of spirituality meant to you in the context of natural medicine education?’ The students responded vigorously to this question, with many of them pointing to a possible gap in their training concerning the concept of spirituality, though by no means did all of them consider that it was a valid or necessary component. One student responded as follows: Spirituality is not deliberately taught. It comes through in peppered bits. It’s in homoeopathy, but you only get it in naturopathy if the lecturer thinks it’s important to them. It’s not a core part of the course. You might get it in herbalism if you get the right lecturer (US2). A similar feeling was expressed by another student, who said: I think the leaning of the lecturer determines if you get taught about spirituality. If they think it’s important, we get it, otherwise, no (US1). When asked to expand on the observation, the student added: A lecturer might refer to spirituality, like they might acknowledge it in passing, but that can be all. If it’s part of their practice, then they’ll talk about it. There’s one lecturer it matters to, so we hear it there (US1). I think it would be good to learn about it, offered another, isn’t it part of the philosophy. I wouldn’t have a clue what to do with it though, I mean if someone asked me about it in clinic I would not know what to do (US7).

The comment implied that spirituality was something the students got by accident, or could seek out through choice of lecturer or by looking elsewhere if they felt it was really important to them in their professional development. One student stated, for example, that: Fortunately for me I took two other units that were extras to the naturopathy course; spiritual wellbeing and a nursing unit that helped me get a grip on the spiritual component of health. I took them because it interests me and it wasn’t in my program. Of course it’s always in homoeopathy. Everyone knows that (US2). This last comment echoed what other students had said, that is, that the philosophical base of homoeopathy included an understanding of the spiritual component of illness and that, to study and comprehend homoeopathy, it was necessary to embrace that construct. When they studied homoeopathy, however briefly, they were inducted
into knowledge and awareness of this component of health and healing. These responses let the researcher know that the subject of spirituality was a gap in the program of which students were aware.

The fourth question in the interview schedule asked ‘what manifestations of this notion would you identify in the curriculum offered by your college?’ In response some students in the interviews reflected how this would play out when they were working in the student clinic on their practicums. One student commented: *I am okay if the person is a Christian because I am a committed Christian so we could talk for ages, but anyone else I would feel really uncomfortable with* (US3). In discussion with the researcher it was explained that this meant that the student felt they could only talk within their personal beliefs. The student went on to explain: *If a person tells me they’ve got some problem because of their star sign then I just can’t get with that. It’s too wacky for me. What if they think wearing a red string around their wrist is going to make them well? What do I do then? I don’t know, so I avoid the whole thing* (US3).

Another student also expressed concern about the ability to work in the student clinic with regards to the spiritual component of health, saying: *We got taught interpersonal skills and all that, but I don’t know how you would speak to someone about spirituality. After all, how do you do it and is it our business?* (US2). Another followed a similar line stating: *I think if we were made to study like apprentices or with mentors then we could work with someone who would show us how to incorporate spirituality into a consultation but I wouldn’t like to do it on my own, because we haven’t had any training and what do we talk about? I mean, really.* (US1). The fourth question brought forth student anxiety about expectations in their student clinic. There was an awareness of the possibility that people might want to talk about spirituality and this served to make them conscious that they were quite unprepared to meet with a patient on this level. They repeated the statement that homoeopathy provided instruction about the spiritual component of illness and that it was possible to miss learning about it completely if they didn’t take the homeopathy electives.

When the interviewer brought the focus to whether spirituality was taught in the day-to-day study, one student expressed a frustration with the balance within the course: *It’s science,*

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17 Students are required to complete supervised clinic hours as a part of their award. This experience is either referred to a ‘clinic’ or ‘practicum’.
science, science, and you can completely forget you are studying naturopathy (US1). Another commented: if you want to learn about spirituality then you have to take all the homoeopathy units because it’s all the way through there. You can’t get through homoeopathy without getting that, but you can pretty much avoid it completely in nat (US7). The comment echoed others in saying that homoeopathy provided a place to learn about the spiritual component of health.

The fifth question in the interview schedule asked: ‘how important do you feel it is for students to be provided with opportunities for spiritual and philosophical growth?’ One student was emphatic: I think there should be more of it and they should ditch the science. After all, health is an entirely spiritual thing isn’t it? I mean you’re nothing if you don’t have your spirit (US1). This sentiment was echoed by another student, who observed: Of course we should have it. I don’t see the university agreeing though. It might be too airy-fairy for them. They are pretty conservative (US6). The viewpoint echoed some expressed concern about the university setting: The university is really well organised and I like that, but they don’t let us learn about things like Bach flowers18 because they think it’s too ‘out there’ (US2). But some students were uncomfortable with the idea of having to dig deeply into who they are and debate worldviews: I’m not sure I want to go there with people I don’t know. I think that stuff is private (US5). One student, in particular, expressed vivid resistance to opening that part of the self for scrutiny: I hate this. I am here to pass, not to explain myself. I think the whole thing is some lecturer having a wank19 at our expense. I mean, are we supposed to think about ghosts and spirits and that? That’s not what university is about. It’s not logical at all (US8).

While the attitude seemed rather defensive, other students expressed interest that was mediated by practical concerns: I think we should go on retreats and that it should be a part of the degree. It would do us good as a group to have time to bond together and explore ideas, but it would have to be part of the course. There’s no time, the course is packed and it’s hard just keeping up (US3). The concern about finding space in the course came through from comments made by another student: I think spirituality is really important but I can’t see where it would fit (US5). Another said: I would love to do that. It might make the course feel more real, like more about naturopathy and less about learning all that chemistry (US2). One

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18 Bach flower remedies is a healing system developed by Dr. Edward Bach in England in the 1930s, which proposes that distilled essences of particular flowers have a relationship with designated emotions and can be used therapeutically. This is a system of energetic medicine which claims to work on an subtle level of healing.

19 ‘Wank’ is Australian slang for masturbatory practices and in this context refers to a person doing something for self-serving purposes rather thinking about other’s needs.
student offered *I would have loved to have gone on retreat and really sink into what it means to be a naturopath. Our herb lecturer took us to the herb garden and asked us to meditate on the herbs. That’s the closest we got to any kind of spiritual work. And if you missed that lecture, well, that was it* (US4).

The fifth question raised some of the sensitivity that can appear when people talk about spirituality. The caution and heat with which the individual interviewees addressed the issue seemed to only underline the importance of tackling the subject, rather than leaving it as ‘taboo’ or ‘too hard’. The students clearly had concerns about it.

These interviews divulged information about the how the inhabitants of the culture of education in naturopathy felt about their training experience. They had issues and concerns. Some of these concerns included confusion about identifying the philosophy of naturopathy, an assertion that homoeopathy was a place to learn about spirituality and a degree of uncertainty about how to work with spirituality in practicums. They worried about losing the course to science. They wanted more but they couldn’t see how it could fit in.

The research moved to the focus groups (which comprised of different final year students); in a move to discover if the comments expressed by other members of the student cohort echoed individual students.

Focus group interview

The focus-group interview with the university students was conducted in the tutorial room in the clinic where the students do their practicum. The undergraduate students (all final year students) who elected to participate were of mixed age ranging from twenty-four to forty-two. There were seven participants in the focus group, four of whom were female. Of the seven students, three had come to university directly from school, and the others had entered the course after having completed other tertiary qualifications.

The students were comfortable with each other and called out greetings as they entered the room for the focus-group interview. There was an atmosphere of camaraderie and goodwill. The room itself was neutral, set up as a clinic training room. It was painted a pale green, had a table, chairs and windows letting in an ample amount of natural light. It was a pleasant room to be in. The same interview schedule as for the individual interviews was used to stimulate
discussion. Students were given the consent forms, a definition of religion and spirituality and time to read these documents as well as to continue to settle down.

The students were asked the first question from the interview schedule, ‘what did they see as the philosophical foundations of natural medicine’. They hesitated and then began making statements about what they thought it was. The tone in the focus group was good-natured, but there was also a slightly defensive air, with students appearing to feel compelled to justify natural medicine in the workplace because of the extra ‘qualities’ it brings to practice. It was hard to tell what had created this atmosphere. The students had just come from an assessment and it is possible they were feeling exhausted or challenged by their work.

The question about the basic philosophical foundations of natural medicine generated an immediate response. One student launched in: I thought naturopathy was about healing and helping people. I really did, and that’s why I came to study this. I feel very strongly that is what I want to do, help people in the best way possible, you know, avoid drugs and things like that (UF5). The comment invoked nodding and agreement in the group: I agree, said another student emphatically. Naturopathy is about giving people choices and options and empowering them. That’s what we do. We practice patient-centred treatment, not like symptom centred. We see people not diseases (UF7). One student also talked about a signifying difference in practice approach, It’s about the innate healing power of the body isn’t it? Isn’t that what makes us different? (UF2). Another talked about mode of practice as a way of identifying philosophical intent stating: We take the time to go deeper and look into what is really going on. You can’t do that in a busy practice (UF4). Another student added: We are here because we believe in a better kind of healing; a method of treating people that is more sensitive and real (UF1). Another said: Our system of healing is prevention and education. We empower people to take charge of their health (UF3). The others agreed: We are all about power and responsibility. When people go to doctors they give their power away. We give it back to them. (UF5). Another added a balancing view: I mean doctors are okay. We work alongside them. But really, people should see us before they see a doctor (UF1).

When pressed to describe the philosophical foundations one student said, heatedly: Look it’s all about Vis Medicatrix Naturae; the healing power of nature. We help people connect with nature. That’s what we do. I wish people would recognise that! (UF2). The other students
laughed and one said: *Oh calm down, we know about it. It’s just we get tired of having to justify ourselves* (UF3). Another sighed: *I get really sick of those lame jokes that imply we are space cadets. They should try doing some of our course.* When pressed further to explain the philosophy, one student said: *We get a bit of philosophy in Naturopathy Foundations and then we work it out as we go along. It’s up to us how serious we get about it* (UF3).

None of these answers described the foundational philosophy of naturopathy clearly and accurately. Instead, these were describing a practice style that, it seemed, the students felt they had to defend and promote as somehow being superior in that it was more caring and more sensitive. In this regard the students exhibited the same passion for natural medicine and confusion about the philosophical constructs as in the individual interviews.

The discussion lead to the second question in the interview schedule, ‘how do you see these philosophical foundations reflected in their curriculum?’ This question also generated debate. One student asserted that: *We were told at the beginning that this was like a pre-med degree. It was kind of off-putting because I thought we were doing something different, not just trying to imitate doctors. It just got worse. From that moment on, we were told about how important science was* (UF1). This frustration was echoed by another participant, a mature-age student, who seemed to be aware of the need for professional competence in a health care setting: *The curriculum is designed to get us into the clinic and to be ‘safe’ practitioners. I wondered why we did organic chemistry. Why did we learn about vinyl? It was a complete and utter waste of time* (UF2). A younger student, who had come straight from school, evidently full of passion and idealism at the time, expressed disillusionment: *It’s not what I came to study. I came to learn about the natural way of healing and all I ended up with was heaps and heaps of science and biochemistry* (UF3). There was some laughter at the comment. Another said: *It’s true, we come to study naturopathy and then we immediately get swamped in science. It’s rugged* (UF2). Yet another commented: *I suppose they had to do it like this to satisfy the uni, and it’s good we get such solid training. I just wish we could get more naturopathic stuff to keep us going* (UF3).

One student commented on the need to study outside the program to gain a greater depth of understanding of human nature as a way of developing a philosophical grounding: *I did a Dip Ed with the School of Education and I learned a great deal about people and how they fit in society, and what being human means. I thought I would learn that in my Nat[uropathy]*
course but it’s not in it. (UF4). Another added: You’d think we would do a course about health and society or something about that – something about how we fit into the bigger picture or why our way of healing is important to people. But we don’t. We learn skills. That’s it (UF6).

These statements suggest that the students felt a need or a desire to contextualise their learning beyond the acquisition of a solid science base and skills expertise. These comments seemed to query the balance in the curriculum design and express a longing for a return to ‘roots’ as a way of coping with the science component of the course. In this regard the focus group was expressing similar thoughts as the individual interviews.

The students were then asked the third and fourth questions about spirituality, ‘what did it mean to them in naturopathy education and what manifestations of this notion would they identify in the curriculum offered by their school or college?’ One student responded emphatically: If you want to learn about spirituality then you have to do the homoeopathy units. It’s all through there. We get it a bit in Nat[urophy] Foundations. And we hear about it from time to time, but it’s not a strong element, no (UF3). The statement echoed the comments from the individual interviews that homeopathy training requires induction into philosophical constructs that include spirituality as a component of health – study of homoeopathy involves understanding that there is a spiritual body as well as physical one. One student said: I think it should be in our program although I don’t know where it would fit. Our course is already jammed (UF2). Another joined in: I think the lecturers know about it but it’s like each is expecting that someone else is doing it, they just stick to their unit. Where would it fit in nutrition for example? (UF4). This comment caused muttering amongst the group. One asked: Maybe it doesn’t belong and you should only do it if that sort of thing matters to you? (UF5). Another student picked up that point and said with passion: Yeah, but then you can miss it out altogether, and it is part of naturopathic healing, isn’t it? (UF3). One of the students snorted and said: Well, I can tell you if it turns up in clinic I would not know what to do. I just try to be as empathetic as possible (UF1). Another agreed: Yes, we’re really thorough in clinic. I mean, we do almost a year there, but spirituality as a part of the consult? Firstly there’s no room and even if there was where would you go with it? (US6).

The sentiment echoed the individual interview comments indicating uncertainty about how to integrate spirituality into the clinic practicums: When we do a consult it can take an hour or
more and that’s only the physical stuff. I wouldn’t want to open up a conversation about spirituality. I would have no idea what to do with it. I mean what if they say they are Greek Orthodox or something? I have no idea what that means. I just know it’s got big ceremonies like the Catholic Church, but what’s that got to do with their health? (UF7). The others laughed and nodded their heads, one adding: We don’t go there because it’s not something we know what to do with. We tick the box on the question sheet and that’s it (UF4).

The concern about feeling unprepared in clinic echoed other comments made in the individual interviews. It was becoming evident that students had ‘views’ about spirituality and reservations about how to integrate it into their clinic practicum. Also that some felt the need to do extra study in other programs to build up their philosophical understanding of health (and society). The students also expressed a passion about health and healing and natural medicine – a commitment that extended beyond becoming equipped for a job.

When the group was asked the fifth question; ‘how important is it, in your view, that students of natural medicine be provided with structured opportunities for the development of spiritual and philosophical knowledge and growth?’ One student stated: I’m not going to pay to go on a retreat and talk about my feelings. I don’t have the money for that. I can always do it later. What’s important is getting through the requirements, not that kind of touchy-feely stuff. I mean, really, we’ll learn that stuff when we get out there. We’re here to learn the basics, that’s it (UF7). At this point the others in the group laughed. One said: Well, you don’t have to talk about your feelings if you don’t want to, mate, but isn’t that what we would learn on retreats, how to handle people and their boundaries and what to do if you feel differently about things from your client, like, what if they are a practicing witch and you are a full-on Christian? (UF5). Others in the group began to argue the point: I think we should get comfortable with this (UF3). Another said: And exactly why? (UF2). The first student responded: Because it’s part of what naturopaths are meant to do. Take care of the spirit as well as the body and mind (UF3). Another responded vigorously: No way am I getting into that! I just want to know they are okay and maybe they have thought about it. I am not a chaplain or anything. Not my job (UF5).

This debate indicated the confusion and lack of clarity that existed around spirituality as a component part of naturopathic practice. In particular, the students could not see its application in clinic practicums. The fact that the topic mattered so much was significant and
possibly linked to the fact that one of the persistent characteristics of comments made by the students was the extent to which there was an underlying feeling that they had somehow been ‘called’ to study naturopathy out of a passion to serve the community and contribute positively to a healthier society through the benefits of natural and complementary medicine. Examples of this sentiment were evident in comments such as: I knew from an early age that I was going to be a doctor or something. When I read about what naturopaths do then I knew that’s where I belonged (UF1). Nodding vigorously, another student remarked: I am studying this because I know it works. My mother was a naturopath and we always had herbs and that in childhood. That really influenced me (UF5). Me too! Said another, I have always wanted to do this, to be able to help people in a real way and help them live really healthy lives (UF2). One of the students sighed and nodded: People make fun of it but natural med is way better than living on cortisone and putting up with rounds of antibiotics (UF3). The comment led to a group sense of ‘superiority’ in their choice of profession: We look into people; we counsel them about their lives and how to live them better (UF2). Absolutely, said another, our work is what gives people power and confidence, not like doctors who write scripts and keep all the power to themselves (UF1). One student stated emphatically: My mother took my baby brother to a naturopath when he was sick and it fixed him right up. Way better than drugs. (UF4). The group gained a lot of confirmation from these remarks and by this time all hesitation was gone as they joined in affirming the uniqueness of their profession and the specialness of their calling.

Overall the focus group was lively and the students argued good naturedly with each other about the course and their issues with it, such as feeling unprepared for integrating spirituality into student practicum. They seemed pleased to have the opportunity to discuss the matter of spirituality and readily got into discussion about it. This may be that were comfortable with each other having moved largely as a cohort for four years, a sense of being a ‘special’ group in a big university and that they were on a ‘mission’ that involved contributing positively to the health of society as natural medicine practitioners.

The private college students

Students at the private colleges were the most difficult to access as three of the four private colleges concerned imposed severe restrictions, not allowing the researcher to talk with the students and stating it was not college policy, without ever explaining the basis for the policy.
The attitude speaks to the competitive nature of private-sector training and is indicative of a level of suspicion and hostility that is widely accepted to exist between private colleges. Of the four private colleges included in the investigation, three of them, Nature Care (NC), Endeavour College (formerly ACNM), and the Southern School of Natural Therapies (SSNT), refused a request for interviews with their students. Permission was granted for individual interviews with students at the Australian College of Natural Therapies (ACNT). Senior (final year) students from ACNT were invited to express interest in being interviewed. Four students volunteered to be interviewed. Additionally, two students who had recently graduated from the college presented themselves for interview after hearing about the research from friends and colleagues. This limited access to individual students was balanced with a focus group of ten other students.

All interviews took place at the college in Sydney. The students were assured of the ethical protocols and confidentiality protections of the interview process. Although the sample of private college students was limited by access problems, the community in natural medicine is small, the student population is mobile\(^2\) and it could be inferred that the in-depth conversations in the focus group as well the interviews, was, to some degree, generalisable.

**Individual interviews**

The interview procedures employed with the university students were replicated as closely as possible. As in the university interviews, the interviews with the college students were recorded, and notes were taken throughout. In the private college, the individual interviews were conducted in an empty lecture room. The room had the look of a deserted classroom with anatomical posters on the wall and leftover lecture notes on the whiteboard. The students themselves were enthusiastic participants. A couple asked if they could eat their lunches as they were in-between classes and this was the only time available. They produced plastic boxes with ‘healthy’ contents such as salads and grain-based dishes (no junk food in this group!). They were mostly dressed informally in the manner of students, in sporting or casual gear. They were given the information sheet and consent form, definition and time to read them as they settled down. The two former students were interviewed in a coffee shop across the road from the college.

\(^2\) In Australia it is not uncommon for students to move between institutions and complete training at a place different from which they started. This mobility creates an ability to compare programs as students converse about their training.
At the beginning of the individual interviews the students were asked the first question on the interview sheet ‘what do you see as the being the philosophical foundations of natural medicine?’ All six interviewees emphatically agreed that philosophy was really important but struggled when asked to define a guiding philosophy. They would pause, laugh sheepishly, scratch their heads, and grasp at ideas that expressed their conceptual vision. Well, one student said cautiously, as if looking for confirmation from the interviewer, it’s about educating people to be responsible for their own health (PS1). The theme of patient education as a way of indicating the philosophical construct of practice was echoed by another: We educate them about what they can do for themselves, that’s what we do (PS3). When the interviewer pursued the question, asking each student to dig deeper into the philosophical constructs of their profession, they started to explain about an aspect of healing that appeared to both fascinate and elude them: We work with the mysteries, one student (PS2) said. Another observed, It’s not us who heals, it’s the people (PS1). The same student said, with passion: We act as a conduit between the universe and this world. We direct energy (PS1). Another said, I think the whole philosophy thing is about working with the body’s energies and with the patient (PS3). As in the university interviews, the philosophy was defined by way of describing practice: We support the body to do its thing. Treatment is a process, not a handing over of things to fix you. If patients want it to work they have to get on board with the process (PS4).

The researcher prompted deeper thought by asking each of the students to try and describe the philosophy of natural medicine. One student commented: The philosophy we learn is about the history of natural medicine and that’s good because that’s where we come from, right? (PS1). Another said: We get the principles and that but because we didn’t have tutorials or retreats you could just write them down and then that’s all. You didn’t have to get serious about it, just remember them for exams (PS2). Another stated, When it comes to integrating philosophy into practice we do a couple of the communication subjects that are specifically designed to get us listening to what people are saying or trying to say, or not saying, I suppose. I think that’s related to the philosophy (PS4). These kinds of responses echoed some of the statements made by the university students in that there was a lot of talking around the subject, a sense of mystification and possible uncertainty and a feeling that the students were still formulating their practice philosophy. It may be that the philosophy is seeded in the studying time and firms up when students graduate and go into practice.
A similarity between the private college students and the university students was again evident in the responses to the second question. That is, ‘how do you see the philosophical foundations reflected in the curriculum offered by their college?’ One student responded: My college was really good on the foundations, I mean we learned about vitalism and that’s a big part of it, right? (PS6). Another ventured: I think that when we did iridology and the humours in herbal medicine, we got to understand things like energetic medicine better (PS5). Another student observed: We did philosophy in first year, which was about the history and the principles. That was good. It was exciting. Some subjects kept that going, like homoeopathy and Bachs [Bach flower remedies] but the others got pretty technical pretty fast (PS3). This comment echoed those made by the university students, in that they would begin to consider the philosophy and try and fix where they had received it in their training. They too identified homeopathy as a place to learn about spirituality.

As noted previously there is a signal difference between the private colleges and the university in that the university does not teach the modality named Bach flower remedies. This is a form of ‘energetic healing’ whereby the distilled essence of particular flowers are said to have unique healing powers that work to establish emotional wellbeing. The university discounts this as a valid therapy and it is not included in the training program. It is, however, often popular with naturopathic students as it combines the so called ‘etheric’ and the natural worlds and signifies an approach to healing that is less technical, subtle and more intuitive. When they study Bach flower remedies (Bachs as it is commonly called in the student vernacular) there is an opportunity for students to develop an approach to healing that is not exclusively ‘science’ based. That is why private college students refer to this component of training whereas university students do not.

The third question in the interview schedule was: ‘what does the notion of spirituality mean to you in the context of natural medicine education?’ One student responded flatly, Well, I wouldn’t know because it’s simply not taught (PS1). Another affirmed the perception of a gap in training: Spirituality is way missing from the course. We got a bit in first year then we never saw it again (PS2). The concern was echoed by another student who worried about the meaning of a potential gap in training: I came here to study about health and people and all we learn is biochemistry and it’s so boring. I hate it. I know I have to do it but I wonder when we are going to learn anything about healing and that (PS3). One student responded bluntly saying, Not much. But she then added, Well, that’s not quite true; to me spirituality means
taking the bigger picture and acknowledging intelligence within the self that is neither emotional intelligence nor mental ability. I think it’s really important but how it gets taught or presented in natural medicine, I don’t know (PS4). Another student talked about the need to understand more: I would love to study it more but it’s kind of big, you know, and it can raise issues with people so where would it fit? (PS1). The concern was brushed aside by another informant who said, We need this stuff. It would be more useful to us than heaps and heaps of chemistry. Least that’s what I think (PS3).

The researcher pressed the issue with several of the students in the interviews by asking what they thought spirituality meant. One responded: It’s kind of like the notion of energetic imbalances that may come from emotional distress or disharmony (PS5). This searching for definition led another student to say: If you mean by spirituality that we get in touch with our inner nature and be all sensitive, then no, we don’t do that. We are taught about being holistic and in homoeopathy we learn about the subtle things in illness, so I guess we get it there (PS3). After thinking more, a student stated emphatically: Look, to be competitive in the market place, I am not going to run around talking about spirituality. Forget that! I am going to present myself as a professional who has studied the medical sciences extensively and done intensive research on nutrition and herbs. I don’t know how spirituality could be taught anyway (PS4). The comment implied a concern about applying spirituality in practice, as if in doing so graduates would present themselves as being something other than ‘respectable’ professionals. The comment revealed doubt and uncertainty that was being dealt with by brushing the concept away.

This led into the fourth question, which was: ‘what manifestations of this notion would you identify in the curriculum offered by your college?’ One student answered: The college offers all the medical science and all the modalities. The nearest they get to spirituality might be energetic medicine. No specific course on spirituality, nothing (PS4). The response was echoed by another student who said: Some of the psychology teaching touches on personal growth or psychological awareness but, as for spirituality, the curriculum seems to have forgotten about these ideas (PS5) This sentiment was backed up by another student: There’s always homeopathy and sometimes, in a counselling unit, it comes up but it doesn’t exist on its own (PS6). The statement confirmed that spirituality was not taught as a stand-alone subject, that they might find it in other units such as psychology or counselling. There was a perception that homeopathy was the only place where it came through in any weighted way.
When the interviewees were asked the fifth question in the interview schedule, ‘how important is it, in your view, that students on natural medicine be provided with structured opportunities for the development of spiritual and philosophical knowledge and growth?’ One student commented: *It’s important but, God, do I want to study any more subjects than what I am already? I suppose it would help tie everything together and give us a greater understanding. You know, pull us out of the minutiae of cells and mitochondria and all of that. You know, remind us why we came here in the first place* (PS4). Another student said: *Well, yes, of course, but I am well sick of paying for all of this and why wasn’t it in the course in the first place?* (PS2). One student stated flatly, *Opportunities for spiritual growth are non-existent* (PS1).

The absence of instruction about the place and integration of spirituality in naturopathic practice led some students to reflect on the implications for them as practitioners and the way they were being prepared in practicums. One said, *In our clinics we didn’t incorporate spirituality at all, which was okay really because we wouldn’t have known what to do with it anyway* (PS3). Another said, *Clinic is really good because that’s where it all gets tied together. Just as well we don’t have to do anything about spiritual stuff though, because we aren’t equipped at all for that. We just skip past that part* (PS1). The impression given was that students liked the practicums: *It’s great being in clinic. Finally we get to treat people and it all comes together* (PS1). They worried, though, about areas they felt unprepared for: *I don’t get into the spirituality thing with patients. Not only is there no time but what would we do anyway, apart from simply acknowledging it?* (PS3).

Some of the private college students took the opportunity to talk about the college’s articulation relationship with the partner-university and comment on the influence on curricula. The formalisation of courses through partnerships with the university sector was seen to have had a strong influence on the way students were taught, not only about philosophy but, also about spirituality. One student stated: *The course became really science focused when the school hooked up with the [named] university. Any spiritual stuff was dropped* (PS1). Another student reported a perception that the changes resulting from partnerships between private colleges and universities were largely negative: *Lots of the program got taught by university lecturers who know nothing about spirituality, let alone natural medicine. All they know is biology and pharmacology and pathology. They dominate the course so there’s no spirituality in it now. University people don’t know anything about*
that kind of stuff (PS2). Another student echoed this view: Anything anecdotal, well they can’t have it because it’s not scientific (PS2). The students frequently expressed a distrust of evidence-based medicine, or what they thought was evidence-based medicine: I know we need to learn about evidence-based practice but it seems like all we do is case studies and they are all about pathology and diagnosis and the nat stuff gets sidelined (PS3). The sentiment, regarding caution and suspicion of the university alliance, was echoed by the two participants from the college: Joining with university is helping us get degrees but they have no interest in naturopathy. You can tell they were just in it for the money (PS5). The other student stated: I want a degree, yeah, but the uni program was no way naturopathic. They looked down on us like try-hards21. We didn’t care (PS6).

Focus group interview

One focus-group interview was held at the ACNT private college, involving ten participants, none of whom was in the individual interviews. This was done to develop the range of views being offered and potentially gather more data from a wider set. The age range of the group was from twenty-two to forty-four; there was only one male student, and all the participants were final-year students. It was held in the lunch room of the college teaching clinic which is situated on a busy inner-city road in Sydney. The atmosphere in the focus group was friendly and relaxed. The students seemed familiar and comfortable with one another. They mostly dressed in the casual manner of students with one or two wearing sporting gear like track pants, and one or two had a more hippy look with dreadlocks, piercings and tattoos. The look was reminiscent of the New Age movement when natural medicine really began to surge in popularity. Some looked more city slick with straightened hair and painted nails. They chatted to each other, while the group was drifting in and settling down, were about topics such as the unjustness of fees, the rigidity of timetables the unfairness of a recent exam and the dress sense of certain lecturers. Students were given the consent forms, definition sheet and time to read these documents as well as to continue to settle down. Two stragglers arrived late and were easily absorbed into the group.

21 Try-hard is colloquial for a person who attempts to be successful, especially socially, but does not succeed.
To initiate discussion they were asked to focus on the first question in the schedule: ‘what did they see as the philosophical foundations of natural medicine?’ There was a noticeable pause before they began to try to answer the question, glancing at each other to see who would take the lead. The younger students appeared to hold back from participation, allowing the four older students to dominate. It was not possible to tell if this was the result of more confidence on the part of the older students in their knowledge or of them simply having more forceful personalities. One responded: *It’s all about being holistic* (PF1). Another agreed: *Each person has their own self-healing capacity* (PF3). Another said: *Prevention too. That’s key* (PF4). These statements were uttered cautiously as if the students were testing their knowledge in the group arena.

In order to further the discussion the researcher encouraged the group to identify what central philosophy natural medicine practitioners hold that distinguishes them from medical practitioners. This prompt gave the group a hook into describing the philosophy and practice of the naturopath. The group began by talking about their style of treatment and how this style affirmed their ‘special’ approach, saying things such as: *We deal with the body as whole. We don’t just do the body systems. We look at people’s belief systems. We go deeper than most doctors* (PF3) and: *We dig deeper* (PF2). These responses signaled a widespread view that naturopaths offered more than medical practitioners, which made them special. The group held proudly to the identity of a natural medicine practitioner as unique, that they were somehow more willing to give of themselves than an orthodox practitioner: *We spend an hour or more with a patient, we don’t look at just the symptom. Like a cold or something like that* (PF5). They backed up their sense of uniqueness by describing their approach in clinic as demonstrative of a unique philosophy and that this approach appealed to people saying: *Lots of people come to see us after they have been to see a doctor* (PF5).

These global statements appeared to indicate a strong feeling about their difference of style and that in some way the practice of their profession was more sensitive to patients and took greater pains to look into what was causing discomfort or harm to their patients’ wellbeing: *Well, you know, we take real care of people. We look into what’s underneath their illness. That’s naturopathy* (PF4). The group held to the idea that they were taking ‘real care’, and that caring in this way was a signature of their profession. When asked to talk in greater detail

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22 Almost all training contains an introduction to naturopathic philosophy in the first term or semester of the first year, as an foundation for future naturopathic studies.
about the actual philosophical construct that underpinned the practice style the discussion became more nebulous as students grappled to express the conceptual foundations of their profession. One student, when talking about the philosophy stated: *The philosophy has a long and illustrious tradition, this is the bedrock* (PF9). It was as if by looking to the historical development the student could gain insight into the structures of practice. When the philosophy proved harder to pin down, the student prevaricated saying: *Natural medicine has a lot of mystery attached and I don’t know why things work, I don’t know how, but they work in mysterious and unexpected ways* (PF9). The students seemed generally to be comfortable in referring to mystery, almost proud and defensive of a style of healthcare that attended to the deeper aspect of being and of health and by inference, one that was being so badly neglected by mainstream medicine.

The discussion continued in the vein of describing the style of practice that demonstrated the philosophy. *I do reiki*23 and *that makes me a naturopath because I deal with the more esoteric side of healing, that’s the difference* (PF5). While the statement was accepted unquestioningly by the group it could be noted that this is the type of remark that gets naturopathy into trouble with the medical profession and allows assertions of unprofessional practices to be held. Reiki is a form of palm healing whereby energy is transmitted to the practitioner from the patient who is resting in a semi-meditative state, through the palms of the hands. Specific movements are made over the body, which are ascribed healing power. While it is an extremely relaxing and calming therapy some of the healing claims associated with the practice are contested. The practice, though somewhat popular, has limited standing in the scientific community and is generally not included in naturopathy curricula.

The lengthy consultation was mentioned several times as something that signified the ‘specialness’ of naturopathic practice, one student even stating proudly: *we might take three hours with a patient* (PF4). This was spoken of as a positive feature of practice that made the naturopathic practitioner unique, special. The lengthy consultation style was mentioned several times as a marker of the ‘integrity’ of the profession in its attentiveness. It would be interesting to discover if naturopathic practitioners of longer standing, whose ambition is to make a living and run viable practices feel the same way.

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23 Reiki is a treatment originating in Japan. The practitioner moves the open palms of the hands across the body, without touching, and so doing promotes balance and wellbeing in body energy.
What emerged was that students were aware of a guiding philosophy but had trouble naming or expressing what it actually was. They could identify the way it affected practice and the style of treatment (lengthy and involving many questions focused on the person rather than a particular symptom) but there was little agreement about what the philosophical structures actually were, only that they existed and made the naturopathic practitioner ‘different’.

A common theme that emerged in discussion was one of protectiveness. The students, when describing their understanding of naturopathic practice were defensive, proud and somewhat smug. Sometimes the tone became triumphant and righteous, as if they had to defend it or justify it vigorously. They would signify their understanding of practice: *We are the ones they come to when the system fails them* (PF3). At this point in the discussion the chorus of students’ voice grew louder and stronger as they talked on top of each other, affirming the signature difference between them and orthodox practitioners. The manner of their speech placed an emphasis on themselves as distinctive among health care practitioners, stressing the word ‘we’. *We take the time to find out what’s really wrong* (PF7). Another joined in saying: *We listen and look at people as whole beings* (PF5). *That’s right! We really listen* (PF10). Others in the group added to the affirmation: *We look at their body language* (PF6). *We notice all the little things.* (PF5). The discussion grew heated and enthusiastic with another student rushing to say: *We pay the special kind of attention that’s missing in general practice* (PF8).

The chorus of affirmations echoed a sentiment expressed in the university interviews, that naturopathy students not only tend to view themselves as having a ‘calling’ to be healers, but that their practice a naturopaths is somehow ‘superior’ or more sensitive to that that offered by a medical practitioner. Whether this attitude is a hangover from a time when naturopaths were outside mainstream acceptance or is symptomatic of disenchantment with technologised medicine is hard to say.

Following this the students moderated some of the comment by acknowledging medical training and the technical expertise of the medical practitioner: *I mean doctors are really good at diagnosis and ordering tests and that* (PF3). Another added graciously: *Some doctors are really helpful and share knowledge* (PF2). There was consensus, however, that somehow the natural medicine practitioner contributed more in the way of sensitivity, greater insight and (possibly) more astute understanding of what was going on with the patient. But the tone of
the conversation had become slightly hectoring. It was as if they felt as a group they were beleaguered in some way and that they had to work hard to justify their existence. It is possible that this insecurity is that of inexperienced students and neophyte practitioners who have yet to test their mettle in the world; however it is interesting to consider if this is, in fact, a symptomatic aspect of the naturopathic profession; that is, insecurity about its identity\(^2^4\).

The students were asked about the notion of spirituality and how it manifested in their curricula. Here the tone changed and there appeared to be division as students talked about a shift in their education. They talked about the growing inclusion of evidence-based medicine, and science and how it was affecting their studies. There was an expression of confusion and resistance in a number of comments. Some sections of the student group expressed concern about the way the curriculum was structured and about how this inclusion affected their ambition to become natural medicine practitioners. They also indicated they felt stressed by the heavy science workload: *It’s not what I came to study. I came to learn about the natural way of healing and all I ended up with was heaps and heaps of science and biochemistry* (PF6). Other students agreed, saying: *all the biomedical sciences dominate the curriculum. There are more of them than anything else. Biomedicine is by far the greatest chunk* (PF7). These sentiments are a common concern expressed by students that there is significant science in the program and how that feels as if it is at the cost of the philosophical foundations. When talking about the philosophy one student noted sadly: *Trad med is bowing to the dominant paradigm* (PF4). Another agreed, saying: *The tradition is reflected only partly in the curriculum. Some lecturers draw on the tradition, others absolutely not* (PF8). From another: *To look at herbs in a modern way, we take out the mystery* (PF6).

A consensus was that the significance of the philosophy was dependent on the commitment of the lecturer. This is a normal event, in that the personal philosophy of a lecture is reflected in the teaching program. As one student observed: *If the lecturer believes passionately about naturopathy, then we are more likely to get the philosophy all the way through the class* (PS4).

\(^{2^4}\) It should be noted that these defensive and somewhat elitist views were more or less absent in discussion with the experienced practitioners.
However, it would seem that the students were detecting a shift in educational direction. One student stated: *The curriculum is a bit schizophrenic. We look at the history and then we look at the constituents. So we alternate between an integrated knowledge and a reductionist approach* (PF5). The comment may relate to a shift in training culture. Interviewees indicated that they felt like guinea pigs as the world of natural medicine shifted to include evidence-based medicine: *We are in transition between holism and scientism and scientism is winning at this point* (PF4) and *The colleges are using us to work out how to get degree status* (PF3). The last comment linked to the concerns students had expressed about the university partnerships.

The students iterated further concerns made in the interviews about when the private colleges began to work in partnership with the universities, making comments like: *Our philosophy subjects really suffered when we joined with a university. It’s like the college was ashamed or something* (PF5). One student was more explicit: *Once they started incorporating evidence-based practices then the whole course changed and then it was like it's science all the way. All the old traditions got really minimised and of course once they stopped naturopaths teaching and started using lecturers then it was really quite different. It was like university had all the real knowledge and all the stuff the naturopaths were teaching wasn’t important or didn’t count. So yeah, philosophy got to be more like a history course* (PF7). The student went on to surmise why it had happened: *I don’t know... it’s how the college gets to be respectable by kind of hiding all that stuff* (PF7). It was as if the students viewed the university-private college relationship cynically and possibly realistically as one that was purely commercial and had to be accepted as a deal necessary to gain a higher degree. The concern for the students was how the relationship was affecting their training in the basics of naturopathic philosophy.

Other students expressed great satisfaction with the science component saying: *If we are going to fit in we have to be able to do the science and talk to people and doctors in their language. Heaps of people look things up on the net and we need to be able to top their knowledge. We need the science to show how good we are. Once we suck them in then we can give them all the natural remedies but we have to show we know that stuff... so they feel confidence in us.* (PF1). Other students agreed saying, *The science is good and that. I mean it makes people take us seriously, doesn’t it?* (PF2). The private college students spoke more than the university students about the value of science as a way of establishing credibility of
their training. In this regard they appeared less confident than the university students who groaned about the science component of their training, but curiously, accepted it as necessity, even as they called for more balance. This could relate to the stronger educational and social recognition of university credentials.

There was a need to focus the group on spirituality and so the group was asked the third question on the interview question sheet and to comment specifically on spirituality as a component of their training. Here two views became apparent. Some felt strongly that spirituality should be included as a key component of the course, others felt it should not be taught, or only in a minimal way. The question raised debate about personal boundaries and practitioner responsibilities. The group raised issues about its placement, weighting in the program and the possible effect that it would have on them in practice. Some spoke strongly for the need for scientific proof, others insisted it was an entirely personal matter that should not be brought up in a lecturer setting. There was some heated discussion about whether or not spirituality should be addressed in their training at all: I think spirituality is important but it’s very personal. I don’t know if it should be thrust down people’s throats (PF5). Another student expressed even stronger resistance: I didn’t come here to learn about all that spiritual stuff. That doesn’t belong here. We are people who heal people using natural medicines not talking about their prayers and that (PF9). Another agreed: I came here to get my money’s worth not to stuff around with group hugs and discussions about how I feel about nature spirits (PF10). Concerns were raised about assessment: I don’t think you can teach spirituality. It’s such a personal thing and what if I disagree with the lecturer? Will I get a bad grade because I believe differently? I mean how can you do that? (PF8). Another student agreed stating: Learning about health has nothing to do with your own personal philosophy or belief. I don’t think that a technical subject should have that stuff included (PF10).

The debate about whether spirituality should be included in training continued. Overall there was unease and concern about the topic: I think spirituality is extremely important in practice, to understand clients. The assignment in first year gave us an opportunity to reflect on our own spirituality. We had a lecture in our first year on it. So we had one two-hour lecture and one assignment. That’s probably about it. We never came across it again (PF6). A fellow student expressed concern at the loss of a spiritual component in their training: I may have missed it but we never learned about things to do with the spiritual side of health. I would include a unit that would get people to look at what they believe, to question their
philosophies, you know, one about their own development (PF3). Another student noted the absence: It comes up in counselling, homoeopathy and clinic. It gets touched on in herbal medicine a bit, with energetics and that. We are told we are treating mind, body and spirit. It’s acknowledged, but beyond that it’s not addressed specifically (PF9).

The role of homeopathy in naturopathic education was raised. A student contributed: If you want to know where we learn about spirituality, it’s homoeopathy. That’s the only subject that seems to be concerned about people as spiritual beings, with etheric and energetic selves that are part of their health. The rest is all body and biochem and a bit of sunshine and fresh air. It’s like spirituality has dropped out of the program altogether (PF2). The comment echoed the statements of others in the university interviews and focus group, that homeopathy was the place where a spiritual component of health was taught.

An issue that was raised was the impact of the gap in training and how it would affect an ability to perform competently in their clinical practice, a sentiment which echoed similar concerns expressed by the university students: We get taught about it, oh yeah, it’s mentioned. But we don’t have the tools to treat anyone (PF8). Another student expressed concern about the appropriateness of including spirituality in the practitioner/patient relationship, commenting: Well, I don’t know if it’s really something we should be dealing with, after all it’s not really our business is it? (PF5). One student spoke keenly about experience in clinical practicums: We meet it again in clinic when we ask people if they have a philosophy or a spiritual or religious practice. But how that information gets used is up to the individual. There is no particular guidance about what do with that information once we’ve got it (PF3). Another agreed about the confusion they felt when they were in clinic, as they were expected to acknowledge and recognise spirituality as part of a person’s makeup, but they didn’t know what to do when it arose: It’s a joke really. When we are in clinic there’s a box on the form people fill out that’s say spiritual/religious affiliation. And people can fill it out or leave it blank. But frankly we don’t know what we would do if they filled it out. We have no idea what to do after that. So we don’t do anything. It’s a big gap in our training. I figure we will catch up with it when we are out in the world. If we want to, that is, I mean the whole thing is pretty tricky isn’t it? (PF7).
Themes from the student interviews

Some important themes emerge from the student interviews. While these are discussed more fully in Chapter 9, it is timely to report briefly on them here. The first is that students generally, whether studying at the university or at a college, appear not to have experienced spirituality as a core curriculum concern in any of their studies except, perhaps, in the unit of studies concerned with homeopathy. Homeopathy, rather than the naturopathy philosophy unit, appeared to be the place to learn about this component of health. Where it is experienced in the rest of the course is the result of the enthusiasm of a committed lecturer. There was recognition of the role lecturers’ personal ideologies play and how the personal leanings of a lecturer would shape their learning.

The second is that students generally appeared to experience a good deal of confusion concerning the meaning of the concept of spirituality and its application in practice and considerable concern about what do with it in their practice. The uncertainty translated into concerns when working in clinic practicums. Students expressed a concern about whether or not they would be able to do their jobs as practitioners properly when they did not know enough about spirituality and its role in health.

They also expressed a lack of confidence with the change in direction when universities became involved with private colleges and when the curriculum began to incorporate the methodology of EBM. The confusion was borne out when students expressed cynicism about the university-private college relationship, and concerns that the naturopathic ‘essence’ of their course was being diluted or overwhelmed by a too heavy emphasis on science. Students expressed opposition and/or concern about the science workload in their programs. There were some mixed views about whether or not spirituality should be taught but there was also a feeling that the philosophy was not a strong part of training, one that had yielded to pressures from outside to make the course more scientifically based.

Another theme was that students of naturopathy express idealism and a commitment to their profession as the one that can ‘save’ the patient and offer a truly caring alternative to practices offered by the dominant paradigm of health. The belief came through in comments which described the way naturopaths operates in practice, how they ‘listen’ more, take more time to consult, how they strive to address the ‘whole’ person rather than just the presenting
symptom. This model of care was seen as complementary and possibly superior to the technological efficiencies of biomedicine.

Concluding remarks

Overall, the interviews and focus groups brought forth the opportunity for active discussion about spirituality and health and revealed some emergent themes. It appears that spirituality is not taught as a discrete unit or course anywhere in naturopathic education anywhere in Australia. It may be taught tacitly or subsumed in other programs. Students are aware of the gap, however there is confusion and concern about how to remedy the situation. Some students feel it is appropriate; others approach with caution, feeling the subject to be highly personal and a potential minefield. The students did not know how to address it in clinic practicum, so commonly they avoided it. Students are generally suspicious of the university-private college interface and see the relationship as one of expedience (money for one group, degrees for another), which benefits to both sides but not necessarily with good educational outcomes. The gap in education raised concerns for the students who mostly dealt with it by either extending their education outside of their core program or sidestepping the issue entirely. The strength of the views held served to demonstrate that spirituality and philosophy matter to students. There is uncertainty and confusion and, most importantly, passion about the issue.
Chapter 8

The lecturer experiences

Obtaining a perspective on the experiences of lecturers in engaging with spirituality in the naturopathy curriculum was considered to be important from the point of view of complementing documentation of student experiences. It was anticipated at the outset that lecturers might be able to provide a more considered account of the ways in which spirituality is embedded in the naturopathy curriculum and that they might also be able to comment knowledgeably on the quality of student engagement with spirituality as a foundational concept in the practice of naturopathy. Interestingly, these expectations did not seem capable of being fully satisfied. Thirteen lecturers in total were interviewed. Each was interviewed individually. Four of these lecturers were primarily clinicians, and this attribute is referred to where it relates to specific comments made by them.

The University lecturers

Interviews were conducted with seven lecturers at Southern Cross University. The lecturers were selected for interview through open invitation and were approached individually for confirmation of availability. All lecturers worked for the School of Natural and Complementary Medicine, (two were casual lecturers, and the rest were permanent employees). Anyone who had something to say on the topic of spirituality and healing was invited to participate. Email addresses were gathered and times for individual interviews were agreed through email exchange. In the initial contact the lecturers were advised about the ethical protocols and were assured about the confidentiality of the interview process. The lecturers appeared willing and co-operative about giving voice to their feelings about spirituality and healing and its place in the curriculum.

The interviews took place in the offices of the interviewees. These offices generally had shelves of textbooks relating to natural medicine, as well as medical textbooks. The offices would hold items relevant to their teaching area, for example, the herbal medicine lecturer’s
office had bottles of herbal tinctures and packets of dried herbs. The nutrition lecturer’s office held pictures of the food pyramid, and many texts on diet and nutrition. The chemistry lecturer’s office held items such as plastic models of cellular connections or a giant biochemical pathways chart. Commonly the offices were ‘soft’, with plants, inspirational sayings and pictures of trees and plants. All the offices looked very busy with piles of paper that appeared to be assignments or research papers.

The same format was used in interviewing protocols as with the students. Time was kept at forty to fifty minutes, conversations were taped and notes were taken. Assurances about the purpose of the tape (to ensure accuracy) and secure storage were given. Notes were taken after each interview. These recorded impressions and any other insights such as body language, relevant to the situation. Participants were guaranteed anonymity throughout the process and all information was maintained and stored according to Ethics Committee guidelines. Should any participant have indicated at any time their wish to withdraw their interview, or any part of it, or from the investigation entirely, then this happened.

Individual interviews

The same interview schedule was used for the lecturers as for the students. The lecturers were asked the first question on the interview schedule: ‘What do you see as the philosophical foundations of natural medicine?’ Overall they were much more assured in their responses, exhibiting none of the defensiveness that came through in the student interviews. When speaking, the lecturers showed confidence and a sense of ‘ownership’ of their place in the world as natural medicine educators and practitioners. They spoke with surety, they did not hesitate to answer nor seek confirmation of what they were saying with the researcher. This confidence was demonstrated by the way they answered the first issue about central philosophies. In this regard the answer was often spontaneous: *It’s simple; naturopathy is about supporting the body’s inherent self-healing capacity* (UL5). One lecturer explained her position: *Naturopaths practice holistically and we try to support the body in its own self-healing mechanism. We help by getting out of the way, if that makes sense* (UL6). The lecturers almost uniformly nominated key aspects of the philosophy such as *Vis Medicatrix Naturae*, vitalism, *Holism* and the importance of educating patients about their health as central to their practice as being planks in naturopathic philosophy. One senior lecturer, who had spent some years in practice before returning to teach, stated firmly: *We teach the*
students all the principles and then it’s over to them. Naturopathy is about vitalism and respecting the body. That’s what they need to know (UL2). Another lecturer was equally explicit, stating: The students learn about our approach to healing, one that minimises intervention, promotes patient responsibility and uses natural products as an adjunct, where possible (UL4). When asked how a naturopath differs from a medical practitioner the same lecturer stressed: Our whole approach is holistic and patient-centred. The tools we use are ones that support natural body processes, not ones that interfere with it (UL4). Another interviewee supported that statement saying: Each person has their own self-healing capacity and we are made to be well, not to be sick. This self-healing capacity is key to the way we practice. Also prevention... and first, do no harm. Those are really important things for a naturopath (UL3). The lecturers appeared to be more secure in their philosophical construct, referring to vitalism and holism as key. At this stage spirituality was not mentioned. The lecturers did use a description of practice style to illustrate the difference between themselves and regular medical practitioners. In this regard they adopted the same position as the students; however they talked more positively about cooperation between the natural medicine and biomedicine. One lecturer who had been in practice for some time stated: When we work with other healthcare professionals we have something unique to offer I think. We can give a level, a type of care that is not always there and we are so much about prevention we can really contribute the health of the population (UL5). The remark was echoed by another who stated: When you work with a doctor who is willing to refer to us then things can go well for patients. They can get the diagnostics of biomedicine and the deep holistic care of the naturopath (UL6).

The lecturers in considering the first question had similar philosophical outlooks; that naturopathy was based on prevention, holism, vitalism and the using of natural products such as herbal remedies and nutritional adjustments. One of the interviewees who was also a practitioner, talked about the element of intuition as part of naturopathic practice: A consultation can take up one-and-a-half to two hours. It varies. Sometimes I just know what’s wrong and I cut to the chase (UL1). She meant here that once she had collected physical data she followed her gut feeling. This manner of understanding practice relates to Richardson’s (2002) mention of the murky depths in consultation that bear fruit for an observant practitioner. This way of trusting instinct and intuition was offered as a natural approach to naturopathic diagnosis and treatment and was backed up by other interviewees. Another lecturer said: When I am in clinic I listen to my intuition. Then my logical mind comes in and I
check, but nearly always my intuition is right (UL5). When asked to comment further deeply on this more nebulous aspect of the philosophy one lecturer spoke of the importance of connecting with forces outside the domain of normal physical diagnosis: *My guiding philosophy is that everything is connected. I mean, when I work with someone I am treating the whole person. I try to connect with the person to give them what they need. I keep digging down through the layers because I know illness has an emotion cause. A spiritual cause. I completely trust my intuition* (UL6). Another informant alluded to this ‘extra’ dimension in practice by saying: *I try and give the students a thorough grounding in approaching the patient as whole and listening on every level. I want them to learn to trust their instincts, their intuition* (UL7).

Another lecturer also said: *I rely on my intuition. I use it all the time. I think everybody does. Doctors too* (UL6). Intuition is not something that is written about in the philosophy however it came through in interviews as a technique or approach that was considered valuable and part of naturopathic practice. This ‘tacit’ component of naturopathy came through in another comment: *I trust my inner voice, my intuition if you like. I know it sounds dodgy but I have learned to respect that way of knowing about things* (UL5).

The second question in the interview schedule asked ‘How do you see the foundations reflected in the curriculum of their college/institution?’ One lecturer described the philosophy component of the curriculum as: *...an isolated island in the program* (UL1). The statement seemed to indicate a concern that the philosophy was not integrated and this feeling was echoed by another lecturer who said: *The philosophy is central to everything we do as professional naturopaths. I think they get it in the beginning and then, ideally, it gets reinforced and integrated all the way through until they get to make it real in clinic. That’s the ideal. I couldn’t say for sure that was happening* (UL5). The remark related to an assumption that lecturers relied on the clinic practicums to affirm naturopathic philosophy, an assumption that linked in with other slightly wishful statements that students learned about the philosophy ‘somewhere’ in the course. It appeared that there was a lack of confidence about what was actually happening in clinic: *I am not really sure what happens there. I think they get awfully good at case taking. What they learn depends on the philosophical position of their clinic supervisor. If the supervisor believes in homoeopathy for example then they will get more on a person’s spiritual wellbeing. If the supervisor is keen on nutrition then they will learn a lot about nutrition. As long as they change supervisors it should work out okay* (UL7).
The reality of the university clinic experience was reported by one of the teaching lecturers: *They don’t learn about how to do anything about spirituality in clinic. No. They learn about mind/body/spirit but in clinic we teach the spirit stuff when we do the gaining trust thing with the patient* (UL7). What the ‘spirit stuff’ actually meant was not described, however the term seemed to imply that spirituality was possibly not well regarded, that is, it was seen as another ‘thing’ that teachers had to deal with in the clinic setting. Referring to spirituality as ‘spirit stuff’ seemed dismissive; just another thing for lecturers to cope with in their courses. The term was by other lecturers in passing, possibly denoting a lessened regard for spirituality in the academic context.

The third question asked: ‘What does spirituality mean to you in the context of natural medicine education?’ One lecturer stated: *I see spirituality as being rather underplayed. It’s there in the notion of individual prescribing and the healing journey of the patient. Mostly students are left to find their own way and make their own judgments* (UL3). Another commented: *I think it’s vital to encourage spiritual growth* (UL6). The lecturer explained: *If a practitioner is constantly evolving as a human being towards their concept of spirituality then it creates a very important place for healing. Students need to learn about this* (UL6). Another affirmed the belief that spirituality was a key part of naturopathic education, saying: *Students need to be taught. Homoeopathy students get it through and through and sometimes a lecturer will talk about it in passing but I think they should go on retreats and learn to sit with themselves like they do in Vipassana25... something like that* (UL4). One lecturer affirmed the comment about the role of homoeopathy: *Of course you get it in homoeopathy. Absolutely. Can’t avoid it there. Elsewhere, I have no idea* (UL1). Another lecturer said: *Well, yeah, sure it’s important I really don’t know how you would teach it. I do agree if we are teaching holistically we have to do it. But how that’s going to happen, I don’t know* (UL2). Another lecturer stated: *I have always thought we should start classes with a little meditation, the philosophy ones for example. So that students start connecting with that side of themselves. Maybe that would develop a spiritual awareness* (UL1). These musings suggested that the lecturers were aware of spirituality as an important part of naturopathic philosophy and practice but were unsure how to bring it into their teaching.

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25 Vipassana means to see things as they are and is an ancient Indian meditation technique.
The fourth question asked ‘What manifestations of this notion (spirituality) would you identify in the curriculum offered by your institution’. One of the lecturers spoke of a need for this to happen: *It should be in the program, it really should. But I can’t get the support of my colleagues on this* (UL5). Another talked about the assumption that all the philosophy was iterated throughout the program: *I would say every class relates to the philosophical basis. Maybe not when they are learning about flavanoids. But I think it’s relatively well dispersed throughout the course. Least that’s what I think is happening. After all, we are all in the same boat, aren’t we?* (UL3). The comment hinted that the lecturer believed that all her colleagues were, as naturopaths, following the same philosophical line. Perhaps this linked to the ‘passion’ that was evident in students. It could be suggested that lecturers held within them the same ‘passion’ and commitment to natural medicine, tempered by experience. Another looked for spirituality in the curriculum and said: *We don’t have a course just on spirituality. I would say it’s in the philosophy course and maybe it comes up elsewhere, probably in homeopathy* (UL2). One lecturer went on to say something that also confirmed student observations: *Spirituality is taught in homoeopathy, or on the whim of the lecturer. When I trained we learned about it but I can’t say if it is still happening* (UL7). Another lecturer affirmed the belief that philosophy turns up in different parts of the program: *You will get a straight information transfer in the regular science classes; no real room for philosophy there. But that’s okay. It gets picked up in other classes* (UL3). One lecturer commented: *Spirituality is not taught to any great degree in the course. I think we assume that they will pick it up as they go along. It hasn’t been taught explicitly* (UL4). Another lecturer echoed this sentiment: *There’s no actual course on spirituality. Frankly, I don’t know where it would fit. But I think the students would like it* (UL2). These comments revealed a held belief that philosophy and spirituality were concepts that were taught throughout the program, perhaps not explicitly (apart from the initial training in philosophical foundations). It also inferred that the lecturers were thinking that spirituality was being picked up somewhere, possibly in the homeopathy classes.

The lecturers were asked the fifth question on the interview schedule: ‘How important in your view is it that students in natural medicine be provided with structured opportunities for the development of spiritual and philosophical knowledge and growth?’ One lecturer stated: *Anyone who works in healing is constantly presented with the spiritual realm of health and disease. It definitely should be discussed and taught* (UL7). One lecturer commented about students, saying: *They do crave the spirituality stuff, they really do* (UL1). Once again this
way of describing the spiritual component of health as ‘spirituality stuff’ appeared disparaging and was curious in the context of student interest. It echoed another lecturer who called it ‘spirituality stuff’. What the term means is ambiguous – it could be discipline jargon, uncertainty on the part of the lecturer or even a disparaging comment. It was possible the lecturers felt compromised by demand for a topic outside of their domain/philosophical commitment. One lecturer commented on the shift of focus for students, (perhaps as generation Y takes up higher level education) and said: Students have changed. They are much more determined to succeed financially so they think that science will help them be good practitioners more than spirituality [will] (UL5). But this was not what the students whose responses were reported in the previous chapter were saying. The students mostly expressed an interest in the subject, a concern about the gap and an awareness of a deficiency when it came to working in clinic. Another lecturer talked about pressures on students: I would love to see students have study weekends in nature but I have also heard students complain about having to do stuff like that, saying they weren’t paying good money to be in an f-ing spiritual boot camp (UL2). Here the lecturer appeared to be thinking about the conflict between ideals of curriculum and physical and financial realities. Another lecturer stated: Of course it’s important but who is going to teach it? After all, it’s actually quite tricky and needs to have a good science base… is that possible? Students mightn’t like having to do it. Could be troublesome (UL5). The last comment possibly related to two concerns: firstly, lecturers were concerned about raising the subject with students and possibly touching on issues that might be sensitive. The second concern possibly related to concerns about displaying ‘appropriate’ conservatism in educational approach in the university setting.

The notion of naturopathy as a ‘calling’, emerged as a discernible theme in comments made by the lecturers. One lecturer talked about the student ‘journey’ saying: I think that the person studying natural medicine has that thirst for finding meaning in life (UL5). The comment echoed the sentiment expressed by some of the students that studying naturopathy was more than a degree; it was a heartfelt passion. Another lecturer noted: Studying naturopathy is a philosophical journey into themselves. Student clinic is an opportunity to revitalise students’ belief in what naturopathy is all about. That’s where it’s all supposed to come together (UL4). The concept of a ‘calling’ relates to the passion the students expressed about naturopathy and how committed they felt to it.
Private college lecturers

Six individual interviews were conducted with private college lecturers. These lecturers came from two private colleges. There were limitations placed on access by three of the private colleges who refused to allow the researcher access to staff on site. However lecturers who had worked for both Nature Care and the Southern School of Natural Therapies agreed to be interviewed. Three (Nature Care) were interviewed in their own homes and one (Southern School of Natural Therapies) was interviewed via telephone. One interview was conducted at Endeavour College and one was conducted at Australasian College of Natural Therapies. The following protocols were observed: Time was kept within forty to fifty minutes, conversations were taped and notes were taken after each interview. These recorded impressions and any other insights, such as body language, that were relevant to the situation. Participants were guaranteed anonymity throughout the process and all information was maintained and stored according to Southern Cross University Ethics Committee guidelines. Should any participant have indicated at any time their wish to withdraw their interview, or any part of it, or from the investigation entirely, then this happened.

The interview settings varied. For example, the three interviews conducted with the Nature Care lecturers were in private homes and were relaxed and friendly. The homes had evidence of pets and children, soft furnishings, photos of family on holidays and food cooking in the kitchen. Interviews were conducted in settings such as at a kitchen table or on a verandah overlooking a garden. While family members were not present there was, in all the homes, an atmosphere that was warm, welcoming and comfortable. The interview with a lecturer at Endeavour was conducted in the college cafeteria. The interview stayed formal and restrained and there was very much a feeling that this was an official duty, perhaps something like a press conference. The interview with the lecturer at Australasian College of Natural Therapies was conducted in an administrative office furnished with office equipment and not personalised in any way. The interview with the Southern School of Natural Therapies lecturer was conducted by phone.
Individual interviews

Lecturers were interviewed using the same interview schedule and working through the questions. The first question they were asked was ‘What do you see as the philosophical foundations of naturopathy?’ Well, said one lecturer, it’s all about patient management. While biomedicine is symptom-focused, naturopathy looks at the whole person and then uses the raft of tools available. What tools they use depends what school they trained at. Wherever you trained influences what tools you use (PL1). The comment referred to how colleges vary in training content. For example, a student may or may not learn about Bach flower remedies and the amount of homeopathy in their program is likely to vary. Another lecturer made a reference to holism by saying: We start at a place that everything is connected. It’s not just prescribing nor is it counselling; we look at the whole person (PL2). Vitalism was mentioned: It’s about the animating force which organises the body and which tends toward self-healing (PL3). One of the lecturers referred to a practice style that conferred patient responsibility saying: As a naturopath I try to connect with the person to empower them so they get what they need (PL2). Another lecturer took a pragmatic approach stating firmly: Naturopathy is a system of health care which uses a variety of modalities such as herbal medicine, nutrition, diet, supplements, flower essences to restore vitality and wellbeing (PL4).

Another lecturer stated: I function differently from regular practitioners because I like to get to the cause. More than anything else, I try to connect with people’s guides and let them tell me what’s happening. Then I check it against my scientific analytical mind. It’s essential to have a blend of spiritualism and science to be a good practitioner (PL5). The informant was the only one to mention working with people’s guides (e.g. spirit guides). However, intuition was mentioned by the university lecturers as a key feature of naturopathic practice and this perhaps relates to a style of treatment where the practitioner practices ‘deep’ listening skills.

The second question in the interview schedule was ‘How do you see the foundations reflected in the curriculum at your college?’ One lecturer said: Some psychology touched on personal growth and awareness but the curriculum seems to have forgotten how to teach about these ideas [of philosophy] (PL3). Another lecturer referred to the teaching of the historical development of natural medicine as a way of establishing the philosophical foundations: our

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26 Spirit guides are part of a belief system, which holds that we are surrounded by invisible presences such as angels or nature spirits who protect us and guide us. These guides can be accessed through practices such as prayer, ritual, and meditation. In Indigenous Australian culture it is not uncommon for Aboriginal people to have a totem that guides and informs life.
teaching is eclectic and we draw from people like Culpeper, Galen, Hippocrates, wise women, Hahnemann to stimulate understanding through the historical underpinning (PL1). The approach indicated that viewing naturopathy in its historical context was a way of framing knowledge and possibly also to remind students of the earthy roots of the modality, perhaps to remind them of the ‘back to nature’ practices of naturopathy. One lecturer noted that students feel ‘called’ to work in natural medicine and are keen to get to grips with the philosophy by saying: The students come in all keen and all full of the passion to be healers, they are so keen to learn about the philosophy. We try and give it to them (PL5). Another informant echoed this: The students wanted more on this topic [philosophy]. It’s a high interest program for them. They love the philosophy component of natural medicine and want to learn more just twelve week [twenty-four hour] in the four-year course. (PL5). The idea of students seeking something of personal significance in their training was echoed by another lecturer, who said: I think a lot of people are searching spiritually when they come to naturopathy. That’s the juice they are looking for (PL2). These comments echo other statements in the university interviews where it was identified that students feel they are on a unique and special journey when they study natural medicine.

The third question in the interview asked ‘What does the notion of spirituality mean to you in the context of natural medicine education?’ One lecturer commented wistfully in specific regard to spirituality: There’s no specific unit. We teach them counselling and flower essences and that feeds into it (PL1). The idea was affirmed by another: It’s not in our course. You will always get it in homoeopathy, but you can also avoid it. Depends on the commitment of your lecturer (PL5). This was the notion that instruction depended on the choice of lecturer or came in homoeopathy, a notion that had been heard in the student interviews. We consider it important, said one lecturer: At our college we train people to be complete healers. We don’t have a specific course on spirituality. I would think it would be in the philosophy course. Of course you can’t miss it in homoeopathy (PL4). Here again was the belief that had been echoed in other interviews, that spirituality was in the philosophy unit. It might turn up in other units, mainly homoeopathy. One lecturer agreed on how the passion or commitment of a lecturer can influence teaching but went on to talk about the need to teach students carefully, by observing thoughtfully: I think they need to learn it. [Person X] was brilliant at it when I trained. You would have to be careful it doesn’t sound religious. That would put people off. It needs to be introduced as a part of practice approach (PL6). The last comment intimated that
there was a concern that students would need to learn about spirituality in preparation for practice.

The fourth question on the interview schedule asked ‘What manifestations of the notion of spirituality would you identify in the curriculum offered by your college’. The comment affirmed a belief that philosophy was a starting point. By way of solution one lecturer offered: *I think if we make them study the history more then they will get it. I mean in a deep way. It drives me mad when all naturopathic learning gets reduced to measurement and symptom. I mean what’s that all about?* (PL2). Another lecturer made a similar comment saying: *The history and philosophy of natural medicine would be a beautiful course* (PL6). A lecturer stated firmly: *Our students get introduced to the philosophy and then they learn the tools of craft and then they go into clinic where it is all drawn together. I would think that the intro course and the clinic are like bookends and that’s how they learn about spirituality in practice: maybe not specifically, but as an overall part of holistic practice* (PL4). Yet another lecturer affirmed the understanding that homeopathy held its philosophical content very strongly saying: *If you want to learn a lot about philosophy and spirituality then you have to study homoeopathy. You might get it a bit in herbs and maybe in massage but that’s it* (PL3).

It also affirmed the common view that spirituality was carried forth by colleagues who had a personal commitment to it but could always be found in education about homoeopathy. A college may carry an elective that covers the concept of spiritual healing: *At our college we have a subject called energetic healing* and that is good for students who want to find out more about that kind of thing (PL2). The comment referred to a style of healing which approaches health on a more subtle level. The subject is not taught in the university model.

When asked the fifth question on the interview schedule: ‘Do you feel it important to give students opportunities for philosophical and spiritual growth?’ one of the lecturers stated emphatically: *I think it’s critical for students to be given opportunities to develop their philosophical views. I would have liked them to have the opportunity to do a term-long unit looking at issues around spirituality and health. Because the curriculum is now so heavily based on the medical science they can kind of avoid the spiritual thing altogether* (PL1). The

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27 When working with ‘energetic’ healing a practitioner may try to understand the body using techniques that read the body differently from accepted norms. Such techniques may involve kinesiology, palm healing, reiki, colour therapy, Bach flower remedies. These typically involve sitting quietly with a patient and ‘listening’ though the palms of the hands; the tools are said to work on the ‘subtle’ anatomy of the body.
statement echoed that of the common student perception that the course was too heavily skewed toward science.

One lecturer talked about the need for opportunities to develop philosophically and spiritually: *I do think it is important. Comparative religion and an understanding of how people use and rely on faith would be useful in education. It would certainly help them relate to patients in a more compassionate and understanding manner* (PL6). Another lecturer commented: *Spiritual distress comes through in people’s diseases. It’s always a consideration; I mean how much spirituality matters to people* (PL3). This was assumed to mean that, when illness strikes there is a spiritual component and this is something the naturopath needs to attend to. The lecturer added: *I believe spiritual healing is the only one that works* (PL3). The comment possibly told more about PL3’s personal philosophy of healing than what should be taught to students, however, PL3 added: *Because we are doctor as teacher we need to teach students how to access those parts of themselves that will be useful to them in practice* (PL3). Another comment made was in line with this when the lecturer stated simply: *Self-development is critical to being a practitioner. I believe you can’t be a really effective practitioner without it* (PL4). One lecturer sighed heavily, indicating they were thinking about what was happening in education and said: *they really should more opportunities to develop, yeah. Allowing them to have electives like colour therapy, astrology, whatever, is really helpful* (PL1).

The question also stimulated a response that seemed to be one of concern about the future of education in naturopathy: *I think they get a lot in intro to nat and then they get stuck on what Vitamin C does and what this part of the body does. I am an old-fashioned naturopath, I’m the generation who sat on the border between spiritual and philosophical way and now its all clinical trials and newer jargon that comes with it like ‘evidence-based’. I see the point of EBM but I have a horrible fear what’s happening to natural medicine. That we are going to lose all the stuff at the heart of it all* (PL6). The doubt was heard again in concerns about the direction of naturopathic education. Another informant commented on the inclusion of EBM: *I think it’s really been good for our profession to have more evidence-based studies, I really do. What I don’t like is how everything has become case-based and we don’t seem to be thinking about holism so much anymore. You go to a conference and its one case study after another* (PL5). One informant spoke with force and verged on irritation saying: *We need to get students back to the heart of healing. When they are in clinic and looking a how many mls*
of this and how many drops of that, it’s crap, it really is. Excuse me, but I really think that (PL1). The concern was echoed in comments about clinic practicums. A lecturer said carefully: *Us supervisors in clinic work against that rigid thinking that is all about measure and dose. The spiritual component is really important. In clinic we try to bring them back to their roots* (PL5). This appeared to indicate that in the clinic practicum the lecturers were working to re-establish the naturopathic ‘flavour’ of training, as a way of resisting a perceived push toward science.

The interview questions stimulated the lecturers to think about their own training, what had inspired them to train and what was useful to them after graduation. One lecturer looked back on her own training and compared it to the current reality saying: *When I trained I had a brilliant lecturer how taught us that health reflected life and we were all spiritual entities. I doubt that’s being taught now* (PL2). One lecturer said: *Philosophy at my college really put forward the vitalistic view. Herbal medicine also talked about when it went into humoral theory and energetic medicine. Subjects like iridology\(^\text{28}\) and homoeopathy reinforced many of these ideas* (PL3). One lecturer was less romantic noting: *We were taught philosophy in a crude form. We were made aware of it in self-development and that was left up to the individual. If we had a teacher who was passionate about philosophy we got it; if they didn’t feel it was important then we didn’t get it* (PL4). Another lecturer contributed: *the college I went to I chose it because it had a reputation for being more spiritual. And it is definitely, more than the other ones* (PL2).

Lecturers went on to describe their experiences working in the private college system, particularly before engagement with the universities and the process of accreditation. One lecturer in particular articulated the concern about a lack of an integrated pedagogical approach thus: *We have never had any faculty or curriculum meetings, so me and my fellow lecturers decided what to teach* (PL5) and another affirmed the approach saying: *I rely on my colleagues to help me decide what to do. There is a lot of autonomy* (PL6).

Some participants were practitioners/lecturers who had graduated in the last five to eight years so they had been through the system at a time when the interface between the colleges and the tertiary sector was happening. They had seen both worlds – the time of autonomy,

\(^{28}\) Iridology is diagnosis through observation of the iris. This is not in the university programme as its validity is questioned.
mixed quality training and curricula, charismatic teachers and then the inclusion into the mainstream system. This gave them insight into a time of change and when considering this a lecturer noted wistfully: *When we studied we went on fasting retreats that I suppose you could call learning about the philosophy and learning to be more spiritual. In that regard we really got into it and experimented with our own health and kind of learned from within. I guess those days are gone now* (PL5). These lecturers were in a unique position to observe the way education had shifted. The expression of regret and longing for the past came forward in another comment: *I think that naturopaths have really gone for the science in a big way to try and be orthodox. It’s mad really because all drugs come from plants. I mean without witchdoctors and the old midwives there wouldn’t be any modern medicine. But the new science... well, they say if its not evidence-based it doesn’t count* (PL6). These sentiments expressed some of the concerns about the university-private college nexus, the changes that had come about with the introduction of EBM and government accreditation and along with perceived nostalgia for the past.

**Concluding remarks**

Several themes emerged from these interviews with lecturers. One was the concern about a perceived dilution of naturopathic principles. A sense of longing for ‘the good old days’ pervaded the interviews, particularly with lecturers who had been practicing naturopathy for a long time. While the research was investigating the culture of education in natural medicine these comments spoke to concerns about the future of the profession. There was a nostalgia for times when teaching was (perhaps) more informal. Lecturers in particular talked about a loss of ‘naturopathic integrity’ in their programs. They were cautious about the sharp increase in ‘science’ at a cost to what they perceived as traditions inherent and central to natural medicine.

The lecturers talked about how they felt that there was a change in training culture that was creating graduates who were more money-oriented, more science focused and less respectful of the ‘old ways’ and the traditional practices of the profession. It is difficult to say how much the shift in the internal culture of naturopathic education was reflective a wider change in the society. All lecturers interviewed observed that spirituality is not taught as a discrete course in any program with which they were involved. This was seen to be an omission and something that students should have as part of their training. There were statements made about how
students looked for this component in their naturopathic training and that a passionate or committed lecturer might bring the subject of spirituality forward, but inclusion would be the ‘luck of the draw’. They also iterated the theme that students were often passionate about becoming healers and that they were on a ‘journey’ when then embarked on their studies.

The issue of the inclusion of EBM was commented on by some, noting that it had changed the way naturopaths approached their profession. There appeared concerns that it has shifted naturopaths away from thinking holistically and brought the focus more closely towards the dualism of science. The observation was balanced by some naturopaths, who talked about the importance of intuition, particularly in clinical situations. These naturopaths were clear and confident with acknowledging and using intuition in practice as another important way of ‘listening’ to patients.

The message that homoeopathy carried a strong spiritual component was also iterated.
Chapter 9

Conclusion

This final chapter seeks to draw together the main insights from the investigation, and to discuss their implications. As will be recalled from Chapter 1, the investigation had as its focus the role and importance of spirituality in the training of naturopaths in Australia. Specifically, three research questions were identified:

• what are the distinctive features of the culture of training programs in naturopathy at a range of Australian higher education institutions?
• within the culture of training programs for naturopaths, is there a common commitment to the role and importance of spirit, as a constituent element in the mind/body/spirit approach to healing?
• what has been the effect, if any, of evidenced-based approaches to health care practice on the culture of training programs in naturopathy?

The purpose of this chapter is to draw together the main findings as they relate to these questions.

Culture of naturopathy training programs

A distinctive feature of the culture of the naturopathy training programs examined for this investigation is the extent to which there was so much passionate commitment to the importance of naturopathy. Lecturers and students alike exuded an enormous sense of pride in being associated with the profession of naturopathy. That this sentiment was so strong and so widespread is interesting in light of the fact that it has been this kind of commitment that has sustained naturopathy from its early days as a field of healthcare practice in Australia. During the past two decades, naturopathy has become more widely recognised and respected in Australia as a profession. For many of the lecturers interviewed, though, memories of when it operated on the fringe of the healthcare system remained vivid. They could recall a time when
admitting to be a naturopath was often greeted with derision, cynicism and resistance. It is not surprising, therefore, that, having continued their practice of naturopathy during these difficult times, they should be so strongly committed to the profession. More surprising, perhaps, is that those in training to become naturopaths should also be as strongly committed, given the much more supportive climate of public opinion that now exists for naturopathy. The students expressed views such as: 

*I am doing this because I believe really strongly that naturopathy is the best kind of health care. It’s preventative and looks after the whole person* (PF7): 

*I think people should see a naturopath first and a doctor last. Drugs should be the last thing you try* (PF5) and: 

*I always knew I wanted to do this. Being a naturopath is about making a real difference in people’s lives* (US2). The students clearly felt that through the practice of naturopathy they could make a difference to the quality of health care in Australia. Some had grown up with natural medicine, and so the decision to become a naturopath had for them been an easy one. For others, there was a sense of rebelliousness in seeking to adopt a new avenue of health care practice that offered an alternative to the biomedical model. For all of them, there was a cost attached to studying to be a naturopath. For students undertaking naturopathy training at a private college, for example, fees in excess of A$10,000 per year were not unusual (that is, A$40,000 over four years).

Another, though somewhat contradictory, characteristic of the culture was a tendency to be defensive. The attribute manifested itself in various ways. Firstly, there seemed to be a high general level of sensitivity about confidentiality in providing information about personal experiences, whether as a lecturer or as a student. Nearly all of the interviewees indicated concern that their comments should remain private. In this regard, lecturers working at private colleges were the most concerned. They were adamant that any views they expressed that were at odds with the views of their employers should not be reported back to their employers. Lecturers employed by the University appeared to be much less concerned in this regard, though, as with members of the student groups, they were conscious of not wishing to say anything that might be ‘on the record’ and attributable individually to them. Secondly, there was a strong tendency, especially among the students, to assert in a manner that seemed at times to verge of a high level of insecurity, the relative advantages of naturopathic medicine, compared with biomedicine. Characteristic comments by students included the following: 

*Why would you go to a doctor when you can come to us? After all we give real care. We listen and we take time. Not just writing prescriptions and pumping people through* (PF8), and: 

*The reasons doctors don’t refer to us is because they are afraid that people will
find out how good we are (PF10). The sense conveyed in many of the interviews was that the culture of naturopathy had not yet matured, and that there was still a need, felt especially by the students, to establish professional identity by asserting a type of superiority of practice style.

On matters of curriculum the overriding concern was with the importance of a construct of health as embracing the integration of mind, body and spirit. Accordingly, considerable importance was attached to treating the ‘whole’ person, having regard to the importance of vitalistic forces. Lecturers and students accepted the importance of studying herbal medicine, homoeopathy, naturopathic nutrition, massage and tactile therapies as part of their training programs as well as naturopathic philosophy and medical sciences. Interestingly, though, inconsistencies between the university and the private college programs could be seen in the relative importance attached to different areas of study. Within the university program, for example, there was a stronger emphasis on laboratory science than was evident in the private college programs. There were also inconsistencies across the private colleges: in one college, as many as 800 hours of clinical practice were required prior to graduation, while in another the requirement was for no more than 380 hours. These disparities in the number of clinical practice hours required by different naturopathy training programs in Australia have been raised before as an issue worthy of further detailed consideration (McCabe, 2008).

The heavy emphasis placed on the importance of scientific knowledge impacted on student engagement. Regardless of whether it was the university or one of the private colleges, the first two years of the naturopathy training programs examined were weighted heavily toward science subjects including anatomy, biology, biochemistry and physiology. The emphasis was, however, not all that attractive to many students, who wanted as quickly as possible to learn about natural medicine and its applications. Their interests lay mainly with herbal medicine, nutrition, tactile therapies – and the philosophical basis for the practice of naturopathy. The mismatch between what students were interested in and what they were required to study, especially during the first and second years of their programs, was cited time and again by them as being a source of stress and disillusionment. This disillusionment was obvious in comments made about university-college partnerships, whereby a private college would provide the initial part of naturopathy training and a university would provide the final part of the training and award a degree. Many of those interviewed, especially many of the students, felt as follows: Once we joined the university, it was science all the way (PS2)
and: the lecturers at the uni knew nothing about naturopathy, we were a novelty to them (PS1).

The challenge of explaining why an emphasis on science, and on the scientific approach to knowledge creation, was important during the early years of naturopathy training programs was one taken up by lecturers. The explanations provided were indicative of some of the pressures weighing on the profession. They said, for example: We need to have a solid grounding in science if we are to be on a par with the medicos (UL 4) and: if we want to be taken seriously as a profession, we have to be able to speak their language. It’s too easy for them to dismiss us as lightweights. Some of them are still anti-naturopathy and being competent in science can stop that (UL3). Not all of the lecturers, however, were as committed as this to the importance of a scientific basis for naturopathy training. Some referred to it simply as an excuse to gain acceptability for the profession in the eyes of other health care practitioners. Others saw it as negating the foundational importance to naturopathic practice of traditional knowledge. Discussion of the topic with some lecturers prompted an unexpected development, that is, the expression of a deep resentment about the emergence and spread of ‘integrative medicine’. This is where medical practitioners borrow selectively from naturopathic medicine, adopting certain naturopathic treatment modalities that have been validated by means of randomly controlled trials. One lecturer referred to this process as cultural pillaging (UL3), and it was evident in comments made by several others that the viewpoint was not isolated. Of most concern was a sense that medical practitioners were profiting from using tools such as herbal medicines or recommending supplements and tactile therapies without really understanding or having any genuine regard for the notions of holism and vitalism.

Other aspects of the culture of naturopathy training in Australian higher education institutions were also suggested by the interviews. One of these concerned the importance and effectiveness of the clinical practicum (whereby a student treats patients in a clinical setting under close supervision by a qualified supervisor). Practicums were valued by the lecturers as providing an ideal opportunity for students to start integrating theory with the reality of practice. For students, however, there was a concern about the extent of their preparedness to move beyond clinical diagnosis. Students talked about a lack of confidence in knowing what to do if and when spiritual needs were expressed by a patient. As noted earlier, the requirements for student attendance at clinical practice sessions varied from institution to
institution and so, therefore, did the extent to which students felt experienced in handling practice settings. Above and beyond their concern about competence with basic clinical skills, however, was a concern that they were not generally well prepared to identify and respond to matters related to the spiritual aspects of health care. In this regard, Appendix 7 provides a discussion of some practical and accessible tools available for spiritual assessment. These tools are applicable and useful in a clinical setting and would make a valuable addition to naturopathic training, especially if embedded in a unit of study specifically focused on spirituality and health.

The topic of partnerships between private colleges and universities, for the purposes of enabling private-college students to have access to the award of a university degree, presented as an issue of some importance to particular groups of students. Students attending private colleges were often inclined to report that they felt that these partnerships were of no greater importance than to enable the students concerned to obtain a university degree. There was a strong concern that the university lecturers concerned did not properly understand the nature of naturopathic training and did not show a great deal of empathy with the principles underpinning the practice of naturopathy. As one student said: The uni lecturers taught their subject, like anatomy, but they didn’t care that we were naturopathic students and might see the body as more than just a collection of organs and systems (PF3). To an extent, then, these partnerships were seen as representing a situation in which the integrity of naturopathic training was being downgraded when compared with scientific training.

One final aspect of the culture of naturopathic training is of note. It concerns the tendency of the ‘older’ lecturers to refer nostalgically to the ‘pioneer’ times, when they felt training was somehow more authentic and truer to the core philosophical roots of naturopathy. These lecturers agreed that greater social recognition and acceptance had benefited the profession and that more institutionalised approaches to the training of naturopaths had improved the overall quality of professional practice. At the same time, however, they recognised a cost: Although it’s what we are all about, the philosophy is weak and it’s getting weaker. It’s such a small part the program these days (PL3) and: Maybe things will swing back, I don’t know. At the moment there’s so much emphasis on evidence-based medicine and case studies and getting good at reading pathology reports (UL3). These sentiments are consistent with McCabe’s (2008) view that more emphasis is needed on the philosophy of natural medicine in naturopathy training programs in Australia.
Place of spirituality

Spirituality is foundational to naturopathy yet it is evident that in the training programs investigated its precepts and its professional implications were not being addressed in a focused and systematic manner. An analysis of the course documentation for five of the largest naturopathy training programs in Australia showed, for example, that none of them provided a constituent unit of studies that clearly and uniquely addressed the topic of spirituality. In contrast, all of them had constituent units of study that addressed topics such as biochemistry and nutrition. Comments by lecturers and students alike confirmed that spirituality was believed to be relevant to an understanding of the practice of naturopathy but the sense of its relevance was not reflected in the importance attached to it in syllabus documents. There seemed to be no concern about its importance with one lecturer commenting, for example: Of course they should learn about it. Its part of what we do and who we are as practitioners (UL4). The general experience of a significant proportion of the students, however, was that it was not addressed sufficiently: We would love to learn about it. I thought we would. I thought that was part of becoming a naturopath (PS5).

It was evident from the interviews that teaching about spirituality, where it did take place, was more likely to have occurred when students were studying homeopathy. This finding is not surprising, in that the practice of homoeopathy necessitates embracing a deliberate and specific philosophical construct, one that drives and determines the clinical approach. Training in homoeopathy requires that students grasp key philosophical constructs concerning the body as having an etheric component. People are seen as being spiritual as well as physical beings. Students appear generally to have found the opportunity to see health and healing from this perspective to have been very illuminating. One student commented, for example: When we studied homoeopathy I really got that people are spiritual and that there are other ways of looking at their health. I loved that. It was what I was looking for in naturopathy (PF6).

Homoeopathy is included in many training programs in naturopathy but it is not one of the traditional ‘pillars’ of the naturopathic curriculum – in Australia these are herbal medicine, nutrition, tactile therapies and medical sciences (such as anatomy and physiology). Depending upon the curriculum design, a student may or may not be exposed to homoeopathy. While in most instances a unit of study in homeopathy is generally included in naturopathy training programs, there are no agreed standards regarding obligatory content. In some training
programs, students can opt to specialise in homoeopathy as a major area of study. Equally, in others, they may have no exposure to homeopathy at all. Thus, while one lecturer may have been sincere in commenting: *We know spirituality is important and we know they will at least get it in their homoeopathy training* (UL4) the fact is that homeopathy is not a compulsory part of all naturopathy training programs, and its absence from a training program could mean that graduates would have had no formal exposure to the concept of spirituality as part of their naturopathy training. The importance of homeopathy as the vehicle for introducing students to spirituality was underlined by the following comment from one of the lecturers: *Spirituality doesn’t exist as a subject in the program I am involved in but I know that for sure they will get it in homoeopathy. You can’t do that subject without accepting that* (PL4).

A great many of the interviewees felt, however, that the topic of spirituality should be more explicitly addressed in the training of naturopaths. Comments from the lecturers included: *Certainly it should be taught, I just don’t know where* (UL1) and: *I think we should take the students on retreats and really explore with them the spiritual nature of being and of healing* (PL2). Students shared this view with some feeling quite strongly about the matter: *We should definitely be taught about it. It’s much more important than all the chemistry we learn* (UF2).

It is informative to consider again the findings reported in Chapter 6 concerning course documentation. What was evident from the analysis reported in that chapter was the strong commitment made to the teaching of science and science-based subjects in the naturopathy programs reviewed. Within the four-year program delivered by the university, for example, students received a one-hour lecture on the relationship between spirituality and health, compared with approximately 350 hours of class time spent on science or science-based subjects. Thus, while lecturers were genuinely sympathetic to the need for students to have a sound basis of understanding the importance of spirit as one of the elemental constituents of health, the message being symbolically conveyed to students was unmistakable. That is, an understanding of the nature of spirituality is of far less importance than an understanding of health-related sciences. Indeed, if students were to complete a training program in naturopathy in Australia without having studied homeopathy, there is every likelihood that they would complete the award without ever having had much formal opportunity to explore the ‘spirit’ dimension of the mind/body/spirit balance that naturopathy holds to be central to health and wellbeing (Fulder, 1996; J. E. Pizzorno & Murray, 2008; Robson, 2003). Of course, it may be that students tacitly acquire an understanding of the nature and importance
of spirituality in the context of naturopathy through their everyday interactions with lecturers as well as through their exposure to clinical experience. The student interviews did not strongly suggest that tacit learning about spirituality did take place during completion of the naturopathy programs investigated. The students identified homeopathy as being the subject within which issues about spirituality need to be addressed but they could identify few other instances where any systematic treatment of the topic was provided. It is curious, then, that spirituality, which is considered to be foundational to the practice of naturopathy, is not more rigorously addressed in the naturopathy training programs examined for this investigation. Indeed, if, as noted, there has been an uptake of programs teaching spirituality in medical training in the United States (Fortin & Barnett, 2004; Puchalski & Larson, 1998), then it would be ironic to find that there is a similar uptake in medical training programs in Australia, ahead of any similar trend in naturopathy training programs in Australia.

A design for the teaching of spirituality in naturopathy training programs has been developed and is presented in Appendix 6. The model seeks to address the kinds of practical issues that arise when attempting to integrate spirituality with health care practice and in supporting patients’ spiritual and religious beliefs. It provides a framework for introducing students to the skills of spiritual assessment, to working in different multicultural, spiritual and religious contexts and to appropriate behaviours and potential difficulties. Reflective practices are encouraged. Incorporation of such a unit into naturopathy teaching programs in Australia would greatly strengthen their philosophic underpinnings and would help to restore a congruency between what the profession espouses as being valuable and what is valued in practice in the delivery of naturopathy training programs.

Evidence-based medicine

The topic of evidence-based medicine has been a theme of special interest in the investigation. As reported in Chapter 3, the influence of an evidence-based approach to health care practice is now widespread, yet there is an issue about the extent to which this approach can be reconciled with the fundamentally belief-based approach of naturopathy. The broader issue has been considered to be beyond the scope of the present investigation, but it did give rise to the following question that was within the present investigation’s scope: what has been the effect, if any, of evidenced-based approaches to health care practice on the culture of training programs in naturopathy?
Evidence-based medicine is widely espoused as a model for achieving the best possible treatment outcomes for a patient by identifying the most validated and reliable forms of treatment for a particular condition. It relies largely on the use of randomised controlled trials to determine treatment efficacy. Traditional knowledge, which has been a mainstay of natural medicine, is thus considered with suspicion until it has been demonstrated to have a very high statistical probability of having an expected impact. Clinical experience is also considerably downgraded in importance, though, as Sackett (1997) has argued, without clinical experience practice risks becoming tyrannised by external evidence – even excellent external evidence may be inapplicable to or inappropriate for an individual patient.

Generally, the students interviewed for this investigation, though broadly familiar with evidence-based medicine as an approach to health care practice, were resistant to it because it was not primarily what they were interested in. It requires the development of a capacity to locate, comprehend and consider the implications of controlled trials. It also inevitably requires an advanced level of fluency in areas of biology, chemistry, biochemistry and so on. It was the need to learn more science that was a major frustration for many of the students interviewed. Comments made included: It’s science all the way these days (UL1) and: Remind me why I came here! I thought it was about being a healer not learning how to read studies (UL6) and: It’s not what I thought it would be. I mean I know science is good and that but when do we learn the nice stuff, the good stuff about people and healing? (PL1). These comments tell a story of students enrolling for their ideals of naturopathy and finding an unexpected level of science in their programs.

The lecturers who were interviewed were a little more at ease with evidence-based medicine: I think EBM has helped strengthen us as a profession. It has made others take us more seriously (UL5). I don’t think we should go overboard on EBM but it does have a place (UL1) and: I think EBM is used way too heavily as the be-all and end-all, but I can see it has value. We just have to be careful not to throw the baby out with the bathwater (PL2). A prevailing view was that an evidence-based approach could help to strengthen the position of naturopathy in the health care system, particularly if it resulted in more research to validate the products and practices of natural medicine. At the same time, there was a general concern, though not felt strongly by more than a small number of the lecturers, that evidence-based medicine could undermine what is unique about naturopathy, turning it into ‘green allopathy’, whereby the
tools of naturopathy are used but the philosophy of naturopathy has been effectively sidestepped.

Evidence-based medicine is, therefore, having an impact on the culture of naturopathy training in Australia. Students are feeling the impact through the strong, and generally unwelcome, focus on basic sciences in naturopathy training programs. Lecturers are generally accommodating its increased importance, though some are far from happy about its influence. The experience of lectures and students alike, however, is that there is not yet a considered and agreed position on the role and importance of evidence-based medicine in naturopathy training. An embrace of it is certainly happening, but not in a way that is strategic or systematic.

Final remarks

The investigation has addressed a great many issues impacting on naturopathy training in Australia. Drawing upon the experiences of lecturers and students at a selected number of training institutions, it has sought to throw light on the culture of these training programs. The context for these programs, both historically in terms of the development of naturopathy training in Australia and philosophically in terms of what is traditionally valued in the practice of naturopathy, has also been documented. Particular attention has been given to the nature and importance of spirituality. As this account comes to a close, it is timely to consider some of the broader implications of the investigation.

It is evident that far more attention needs to be given to the question of how important spirituality, and more broadly the philosophical foundations of naturopathy, should be in naturopathy training programs in Australia. While the lecturers interviewed were generally supportive of the importance of their students having an understanding of these philosophical foundations, the training programs being delivered provided limited scope for students to engage deeply with these matters. The experience of the students was that their exposure to discussion about spirituality depended on whether or not a particular lecturer was enthusiastic about it and on whether or not they studied homeopathy. Naturopathy training programs in Australia may need generally to be less ambivalent about the importance of naturopathy students learning about matters of spirituality. If this area of study is important then evidence of its importance must be reflected in the weighting given to it in the curriculum.
This gap between the stated philosophy and the actual educational practices is serious. If the teaching of naturopathy does not explicitly and in a more sustained fashion give stronger expression to the foundational importance of spirituality, then the integrity of the profession can become the object of suspicion. In short, the education does not appear to reflect the stated philosophy. As one student stated: *I came here with a vision about being a truly holistic practitioner, now I feel like a competent dispenser of herbs and supplements* (PS2).

More profoundly, there is a risk that the belief in spirituality as a component of health, as expressed by lecturers and practitioners, is not being mirrored in their approach to healing. Spirituality is a component of the natural path to healing, but it would appear that the education of naturopathic students does not accommodate this. There is a huge gap in training and this gap raises questions about the authenticity of naturopathic practice. When the education does not reflect the foundational philosophy of the profession, but defers to a medical model of health, the profession is not true to its espoused values. This omission raises fundamental and important issues of professional authenticity and integrity.

At the same time, the context for the professional practice of naturopathy is rapidly changing in Australia. There has been a sharp rise in community demand for naturopathic products and services and as a consequence there has been an increase in the number of naturopathy students, and training programs in naturopathy have gained official recognition within the Australian higher-education system. The experience of the investigation, however, is that these programs vary greatly in some important respects. Programs delivered by the private colleges, in particular, are market-driven. These colleges focus a great deal on matters of efficiency and cost. They rely heavily on part-time academic staff; they are commercially sensitive about matters related to course content; and they do not engage much in collaborative curriculum development. How a culture of openness to critical reflection about the role of spirituality in naturopathy training programs can develop in these circumstances remains to be seen.

Finally, some possible future research directions may be proposed in light of this investigation. The first would involve a comparative analysis of the teaching of naturopathy across a range of different national jurisdictions with a view to developing an understanding of how in different cultural and educational settings the teaching of naturopathy manages to develop in students a deep understanding of what is unique to the philosophy and practice of
naturopathy. The evolution of the delivery of naturopathy training programs in Australia has been affected by conditions that are probably unique to Australia. Though documentation about naturopathy training programs in other countries is as difficult to locate as is documentation about naturopathy training programs in Australia, there is enough already available to suggest that naturopathy is taught differently across the United States and across the different member states of the European Community. These differences are worthy of closer attention because it is through an exploration of these differences that a deeper understanding of what should be essential to all naturopathy training programs can be identified.

A second research direction would be to build on the present investigation by surveying recent graduates to see to what extent their experiences of practising naturopathy have in any way deepened their appreciation of spirituality as a reference point for professional practice. Hardly anything is known about the experiences of recent naturopathy graduates in Australia. If in fact considerations of spirituality play little or no role in their day-to-day work and if in fact these recent graduates can see little or no relevance in spirituality for what they are doing, then perhaps the curriculum of naturopathy training programs may need to abandon completely all attempts to draw upon spirituality as a source of professional inspiration. If this were to happen, though, naturopathy training in Australia would be cutting its ties with a tradition of natural medicine that dates back to the ancient Greeks. Whether it could do that and at the same time remain entitled to claim to be affiliated with the practice of naturopathy is a moot point.
REFERENCES


Appendices

Appendix 1:
Interview schedule

1. What do you see as being the philosophical foundations of natural medicine?

2. How do you see these foundations reflected in the curriculum offered by your school/college?

3. What does the notion of spirituality mean to you in the context of natural medicine education?

4. What manifestations of this notion would you identify in the curriculum offered by your school/college?

5. How important in your view is it that students in natural medicine should be provided with structured opportunities for the development of spiritual and philosophical knowledge and growth?
Appendix 2:
Information sheet

Title: An investigation into spirituality in the natural medicine curriculum in Australian higher education

I am undertaking research for my PhD an investigation into the place of spirituality in the natural medicine curriculum in Australian higher education. Specifically, it seeks to:

- provide an in-depth understanding of the extent to which spirituality is important in the natural medicine curriculum in Australian higher education
- classify and evaluate the ways in which students in the field are assisted to learn about the role and importance of spirituality in natural medicine and
- analyse the range of insights students in the field actually develop about the role and importance of spirituality in natural medicine

This investigation is premised on a view that spirituality is a foundation stone in the practice of natural medicine. The philosophical and historical grounds for this view will be fully developed in the report of the investigation.

The study uses a variety of ways to gather information. Participation in the research project involves the following activities:

1. Participation in interviews to collect information about the role and placement of spirituality within natural medicine curriculum. These conversational interviews will be unstructured with the participant directing the nature of what is disclosed and the researcher contributing to the conversation by way of clarifying her own understanding of things that are said or providing examples from her own observations or perspective. It is anticipated that the duration of each of these conversational interviews will not exceed 40 minutes. This activity will take place at a convenient location suggested by the participant.
No information provided from participation in the above activities will be made public in any form that could identify the participants. Pseudonyms will be used to protect the identity of participants. A list of available counselling services is provided at the end of this form should participants experience any discomfort, however this type of risk is not envisaged.

Participation in this study is strictly voluntary and confidentially is assured. If participants decide to participate, they are free to withdraw and to discontinue participation at any time. Participants are required to sign the following consent form to establish their consent to participate in the study. Participants can also withdraw consent to further involvement in the research at any time and will not need to give reasons or justification for their decision.

My research is being conducted to meet the requirements for the degree of (Doctorate of Philosophy) under the supervision of Professor Martin Hayden who is Head of the School of Education. If any issues or questions are raised as a result of your participation in this research please contact Martin Hayden (Ph: 02 66203160, Email: mhayden@scu.edu.au).

Airdre Grant (Researcher) PhD Candidate
School of Education
Southern Cross University
[02] 6620 3949
agrant10@scu.edu.au

The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee (HREC). The Approval Number is ECN-05-139.

If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the HREC through the Ethics Complaints Officer, Ms Suze Kelly, (Telephone [02] 6626 9139, Fax [02] 6626 9145, Email: skelly1@scu.edu.au)

Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.
Appendix 3:
Consent form

Informed consent to participate in a Research Project

Title: An investigation into spirituality in the natural medicine curriculum in Australian higher education

Researcher: Airdre Grant, telephone [02] 02 6620 3949, email agrant10@scu.edu.au

Please read the following statements and then sign in the space provided to indicate that you would like to participate in this study. If any of the following statements do not make sense, please ask the researcher to explain them in a different way.

• I agree to participate in the above research project. I have read and understand the details contained in the Information Sheet. I have had the opportunity to ask questions about the study and I am satisfied with the answers received.
• I agree with the conversational interviews being recorded on videotape.
• I understand that I am free to discontinue participation at any time.
• I understand that neither my name nor any identifying information will be disclosed or published, except with my permission.
• I understand that the Southern Cross University’s Ethics Committee has approved this project.
• I am aware that I can contact the researcher at any time after the interview. If I have any further questions about this study I am free to contact Martin Hayden by phone: [02] 66203160, or email: mhayden@scu.edu.au.

The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee (HREC). The Approval Number is ECN-05-139.
If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the HREC through the Ethics Complaints Officer, Ms Suze Kelly, (Telephone [02] 02 6626 9139, Fax [02] 6626 9145, Email: skelly1@scu.edu.au

Any complaint you make will be treated in confidence.

I understand that I will be given a copy of this form to keep.

*I have read the information above and agree to participate in this study. I am over the age of 18 years.*

Name of Participant: ………………………………………………..

Signature of Participant: ……………………………………………

Date: …………………………………

I certify that the terms of the Consent Form have been verbally explained to the participant and that the participant appears to understand the terms prior to signing the form. Proper arrangements have been made for an interpreter where English is not the participant’s first language.

Signature of Witness (independent of the research, where possible): …………………………………

Date: …………………………………
Appendix 4:
Definition of spirituality

Spirituality
The word, spirituality, derives from the Latin word, spiritus, meaning breath, and it signifies an individualistic belief system (Aldridge, 1991). Spirituality resists a neat, one-size-fits-all definition and means different things to different people. It does not necessarily have a Christian foundation. It can mean inner strength related to a belief in and a sense of interconnectedness with a higher power. Thoresen (1999) defines spirituality as the search or quest for the sacred in life and beyond, a seeking of answers to life’s most meaningful and vital questions. Creel & Tillman (2008) describe a sense of transcendence, connection with a Supreme Being or higher power, an inspired belief system that gives meaning to life. McGrath defines spirituality something that animates a person’s life of faith (McGrath, 1999).

Religion
Religion comes from the Latin word, religare, meaning to bind, and it is used to describe the formalised set of practices that adhere to belief in a particular deity and is reinforced by a code of behaviour such as going to church on Sundays, or praying at specific times and on days noted as holy or sacred (Moberg, 2001). Religion is described as the organised system of beliefs, practices and rituals and symbols that are designed to facilitate closeness with the sacred and provide the average person with moral and social guidelines for behaviour (Thoresen, 1999).
Appendix 5:
Coding schedule

Participants were allocated a study number according to the site, interview or focus group and occupation as follows:

<table>
<thead>
<tr>
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<th></th>
<th></th>
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</thead>
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<tr>
<td>Focus groups</td>
<td>University students UF 1–7.</td>
<td>Private college students: PF 1–10.</td>
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Appendix 6:
Spirituality teaching unit

Southern Cross University
School/College Health and Human Sciences

Description

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<td>Undergraduate</td>
</tr>
<tr>
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</tr>
<tr>
<td>Co-requisites:</td>
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</tr>
<tr>
<td>Anti-requisites:</td>
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</tr>
<tr>
<td>Other Enrolment Conditions &amp; Requirements:</td>
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<tr>
<td>Student Services Enrolment Category</td>
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<tr>
<td>Graded/Ungraded:</td>
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</tr>
<tr>
<td>DEST Field of Education (FOE):</td>
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<tr>
<td>Credit Points</td>
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</table>

Aims

This unit is designed as an introduction for students in any health discipline to the concepts, science and research of spirituality and health. It will explore the practicalities and issues that arise when integrating spirituality/religion into health care practice and supporting patients’ spiritual/religious beliefs. Students will be introduced to the skills of spiritual history taking,
working in different multicultural, spiritual and religious contexts, appropriate behaviours and potential difficulties. The spiritual and religious needs of patients will be examined.

Objectives

At the completion of the course students should be able to:
1. Explain the difference between spirituality and religion
2. Critically discuss and apply the research in the field of spirituality and health
3. Integrate appropriate skills and knowledge regarding spirituality and health in students’ own health care practice
4. Identify and address the spiritual/religious needs of a patient
5. Identify barriers and boundaries that can arise in a health care setting with spirituality and health
6. Reflect on their personal philosophies and beliefs in regards to spirituality and health.

Graduate attributes

As a graduate of the Bachelor of xxxxxxxxx at Southern Cross University, you are more than just the sum of the knowledge you have acquired through your units. During your studies you will have developed other skills, values and attitudes that are essential for gaining employment and advancing life-long learning. The University refers to these skills, values and attitudes as the Graduate attributes.

In the unit <unit name> you will be assessed towards your attainment of the following graduate attributes, as identified by the School of <name of School>:
1.
2.

Handbook entry

This unit explores the concept, science and research of spirituality and health. Major topics include definitions, historical influences, barriers and boundaries, patient perspectives, multicultural, multi-religious contexts, current research and integration in a health care setting.
Syllabus

Historical influences, definitions
- Investigation of historical associations of health and spirituality/religion
- Definition of spirituality, definition of religion

Why spirituality is important in health care practice
- Spiritual dimension of patients

Review of current research
- Religion/spirituality and mental health
- Mind/body relationship

Patient perspectives
- Pain, suffering, grief, consolation
- Spiritual/religious practices in health

Including spirituality in practice
- Taking a spiritual history, patient-centred approach
- Respect, acknowledgement, supporting patient beliefs
- Referrals and support networks

When to include spirituality
- Timing of spiritual history
- Prayer
- Practitioner time management
- Privacy issues

Consequences of including spirituality
- Positive and negative issues
- Benefits and pitfalls

Barriers and boundaries
- Issues for practitioners
- Patient needs versus practitioner goals
Possibility of harm

- Guilt, shame, fear
- Conflicts when patient religious/spiritual beliefs conflict with health care recommendations or with practitioner personal beliefs

Addressing spirituality in a multicultural, multi-religious setting

- Different cultural approaches to health
- Issues such as food/birth/death/contraception
- Appropriate protocols, sensitivity, expectations

Prescribed texts and materials

To be advised

Recommended reference materials


Student assessment requirements

<table>
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<tr>
<th>Task</th>
<th>Unit Objectives Assessed</th>
<th>Graduate Attributes Assessed</th>
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<td>Participation in class/online discussions</td>
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</table>

*Students must keep copies of work submitted.*

Mode of delivery

This unit will be offered internally and externally. Unit documents are made available to students as print-based versions and also via the MySCU environment as downloads.

Student /lecturer integrity

It is expected that a student’s work will comply with the Lecturer Policy, Chapter 4.20 on Student Lecturer Integrity. It is the student’s responsibility to familiarise themselves with the Policy. Failure to comply with the Policy can have severe consequences in the form of University sanctions. For information on this Policy please refer to the following website:

Student feedback
Students are encouraged to complete the online student feedback on learning and teaching survey. This is offered for all units in every study period.
Appendix 7:
Spiritual assessment

Assessing spirituality

Spiritual assessment is a tool that practitioners can use to establish the spiritual and religious context in which their patient is located. It is defined as "the process by which health care providers can identify a patient’s spiritual needs pertaining to medical care" (Anandarajah, Long, & Smith, 2001 p.84). The purpose is to help with the formulation of a treatment plan that encompasses more than just the physical body. It is a process, rather than a single event, in that the relationship necessary to have a sensitive conversation may develop over time, however, there are tools that begin defining working parameters (Rumbold, 2007). The most common tool for spiritual assessment is likely to be found on the admission forms at a hospital where patients may be asked if they have religious affiliation/denomination and this may lead to a visit by the chaplain. In a natural medicine clinic there may be a single question tacked on the end of the assessment sheet asking if the patient has any spiritual or religious affiliation. It is most likely that practitioners are not equipped to do anything with that knowledge.

The Joint Commission on Accreditation of Health care Organizations (UK) in 2005 stated that it requires organisations to conduct spiritual assessment as part of the overall assessment to determine how denomination, beliefs and practices will influence their diagnosis and treatment and what assistance would be useful to them. Robinson notes that there are four reasons for undertaking a spiritual assessment and these are, firstly, that spirituality affects the prognosis of an illness; it is a variable that helps predict how patients will cope with illness. Secondly, spirituality is an important part of a patients’ lived experience; they will need to work through the impact of their illness on their belief systems to discover meaning. Thirdly, spiritual functioning is dynamic and fourthly, spiritual reflections show how patients are progressing and adjusting to their illness and that spirituality may give indications about suitable interventions to treat problems (Power, 2006 p.16-17).
Accordingly, it is useful to establish patients’ spiritual or religious orientation as it can have direct bearing on their healing processes. Taking a spiritual assessment helps develop a treatment plan that is inclusive. As these are personal and sometimes strongly held views, conversation on the subject can develop more easily in an informal setting, often involve listening and reading a language that is metaphorical and symbolic (Anandarajah, et al., 2001). It does not have to be called ‘spiritual assessment’; some call it ‘quality of life’ – the aim is to have a conversation that is comfortable, safe and inclusive and enables patients to speak about the spiritual matters that concern them. Obviously, as Koenig points out, it is generally not necessary to do so if the complaint is only minor or the patient want only to deal with stomach acidity or a child’s nappy rash (Koenig, 2000b). Education and intelligence allow the practitioner to determine when there is a serious, relevant need. A great deal of nursing and medical literature looks at end-of-life issues as appropriate for spiritual assessment however the spiritual wellbeing of a patient is within the philosophical domain of the natural medicine practitioner and as such is likely to be considered at some stage in the health care relationship.

More formal assessment involves specific questions and may be used to determine if spiritual and religious views or convictions will have an impact on practice, such as concerns with transfusion, philosophies about death, and possible conflicts in treatment protocols. In considering spiritual assessment, Anandarajah et al. recommend some important factors for the practitioner to consider:

Their [the practitioners’] own beliefs and values as these may influence their approach in a situation that requires tolerance and acceptance
The establishment of a good relationship. All practitioner/patient relationships have a critical element of trust and, for a patient to reveal or discuss deeply-held personal views, there needs to be a good relationship.
Sensitivity and appropriateness of discussions, so that the timing and situation meets the needs of the patient (Anandarajah, et al., 2001).

Rumbold recommends sensitivity in approach, respect for privacy, to work as a team with associated caregivers and pastoral carers, to document all needs and responses, and to provide a place for recognition of spirituality within the treatment strategy (Rumbold, 2007). There are quite a few tools for assessment that have been developed in an effort to penetrate and facilitate the practitioner/patient dialogue about spirituality. The HOPE assessment tool
comprises of questions on the areas of Hope, Organized religion, Personal spirituality and practice and Effects on medical care and end-of-life issues.

The HOPE assessment tool is typical in that it is designed to minimize barriers to conversation by having open-ended questions that allow a person room to express their SR understandings without feeling confined by expectation or judgment.

Examples of questions for the HOPE Approach to Spiritual Assessment

**H** Sources of hope, meaning, comfort, strength, peace, love and connection
We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support? What are your sources of hope, strength, comfort and peace? What do you hold on to during difficult times? What sustains you and keeps you going? For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?

If the answer is “Yes,” go on to O and P questions.
If the answer is “No,” consider asking: Was it ever? If the answer is “Yes,” ask: What changed?

**O** Organized religion
Do you consider yourself part of an organized religion? How important is this to you? What aspects of your religion are helpful and not so helpful to you? Are you part of a religious or spiritual community? Does it help you? How?

**P** Personal spirituality/practices
Do you have personal spiritual beliefs that are independent of organized religion? What are they? Do you believe in God? What kind of relationship do you have with God? What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)

**E** Effects on medical care and end-of-life issues
Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?) As a doctor, is there anything that I can do to help you access the resources that usually help you?
Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?
Would it be helpful for you to speak to a clinical chaplain/community spiritual leader?
Are there any specific practices or restrictions I should know about in providing your medical care? (e.g., dietary restrictions, use of blood products)
If the patient is dying: How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?

(Anandarajah, et al., 2001 p.87)

Other tools include FICA (Faith, Importance, Community, Address) developed by Puchalski and SPIRIT (Puchalski & Larson, 1998; Weissman, Ambuel, & Hallenbeck, 1999). These tools are about a series of questions that a practitioner can use to open up the issue of patients’ spiritual and or religious affiliations and obtain some knowledge and insight. Illustration of these tools demonstrates that there has been considerable work put into creating strategic ways to address this aspect of healing.

Struve suggests that even the busiest of practitioners can find time to ascertain whether spirituality and religion is of significance to their patients and that this is more than a polite consideration or courtesy; it is helpful to both diagnosis and the healing process. He suggests a series of simple questions based around religious affiliation, coping, social support and inner life with God (Struve, 2002).
Affiliation
Do you have a faith or religion that is important to you? Are you a member of a religious or spiritual community?

Coping
Is your faith helpful in handling your illness? Does it influence the way you take care of yourself? Do you use SR beliefs to cope? Are your SR beliefs a source of comfort and support?

Social Support
Does your faith community support you during times of sickness or help you to change your lifestyle? Is your faith community supportive? In what way? Are you involved at your temple/church/mosque/synagogue?

Inner Life with God
Are you able to trust (your) God in what is happening? Have you been able to keep a positive perspective about what is happening?

(Struve, 2002)

Potential problems with spiritual assessment

Not all agree that spiritual assessment is a good or worthy activity. There are some difficulties as the outcome of an assessment can be unpredictable. Information may be revealed or unexpectedly uncovered for which the practitioner has no resources. Timing may be another issue. Patients may be already overwhelmed with information and not ready to talk about something they regard as sensitive. While it is understood and emphasised that the practitioner/patient relationship is always about respect and at no time should views be imposed or denigrated, D’Souza (2007) reports that ignoring the spiritual dimension of a patient may leave them feeling incomplete, ignored and this has the potential to interfere with healing.

There are ethical concerns. The patient has a right to confidentiality at all times in a clinical consultation and this need may be emphasised if there are guilt, shame or other confused feelings around a person’s spiritual or religious history and affiliations. The tools for assessment may feel invasive; sometimes all that is required is sensitivity as a style of informal assessment. Questions may arise about the suitability of the assessment tools being used, if there are too rigid, exclusive, lengthy or complex in an already busy appointment. The
practitioner needs to be able to understand the difference between spiritual and psychosocial concerns, and to be able to deal with people who may be seen to have spiritual needs but are unable to express them through physical impairment.

This appendix dealt with the tools of spiritual assessment. It discussed some of the strategies a practitioner can employ in practice when aiming to incorporate spiritual wellbeing as part of their practice protocols and considered some of the challenges that may be encountered. Spiritual assessment raises issues such as ethics, boundaries and appropriateness of engaging in discourse. There are practical concerns. Practitioners may wonder how they are going to find time to do this along with all the other assessments that are part of a consultation. They may have concerns about being either inadequate or invasive or about opening a can of worms that they are not equipped to deal with. There are, however, a number of assessment tools that have been development in the medical profession that could be adopted by the natural medicine practitioners and utilised in clinical practice. It could also be argued that natural medicine practitioners could need to rethink their consultation strategy in order to create space for this type of conversation. There are options. Practitioners should be able to assess if situations needs to include spiritual assessment (e.g. would a sore throat or cystitis warrant it?). Would it be more meaningful in chronic/life-threatening conditions? These queries underpin the argument for education to prepare practitioners to act in a more inclusive manner in their clinics. What is apparent is that there are established useful tools that practitioners could employ; however, at the time of this study the profession appears unready or unwilling to incorporate this technology. The gap in training is not about a paucity of information; rather, it is indicative that the profession, for any number of reasons, is ignoring this information.
Appendix 8:
Prayer

Prayer is a conscious expression of faith and is used as a means of communicating with a higher power. Common techniques involve stilling the mind through techniques such as breathing, chanting or repetition of prayers such as The Lord’s Prayer. Research indicates that when a person does so and the chatter of the mind is stilled, then there are distinct physiological responses. These include a lowering of the metabolism, heart rate, blood pressure and rate of breathing. This is the exact opposite of what happens when someone is stressed. The slowing down is called the relaxation response and is considered both positive and powerful. Illness is a stressful state, on many levels, and the positive effect of the relaxation response affirms the benefit of prayer. There are many different kinds of prayer from simple beseeching to deep contemplative faith. Intercessory prayer is used a lot in times of illness. This is systematic prayer, organised, committed and regular and generally always used by those who believe they are praying to God. Jantos and Kiat (2007) classify the mechanism of prayer thus:

*Conversational prayer* – an informal discussion with God about day-to-day matters and so forth

*Meditative prayer* – the contemplation of spiritual themes and the relationship between the Divine and mankind

*Ritual prayer* – the recitation of chants or well-known prayers like The Lord’s Prayer

*Intercessory prayer* – usually characterised by petitions by self or by others for health and wellbeing

Jantos and Kiat (2007) further report that there are four possible mechanisms through which prayer has influence of health. There is prayer as relaxation response – this relates to the physiological response to sitting in a quiet place and stilling the mind, the same positive impact that is experienced by meditators (including slower heart rate, lowered blood pressure, slower brain wave activity, peripheral warming, and a sense of calm and increased sense of wellbeing). There is prayer as placebo – trials have been conducted in an effort to measure prayer in healing and health, but they run into obstacles as results are hard to quantify – e.g.
how to you measure the strength of a silent prayer? Work continues in this area. Prayer can be an expression of positive emotions – prayer often engenders positive emotions, good indicators for health. A person who prays might expect to feel calm, hopeful and less turbulent in their moods, encouraged, peaceful and joyful and these positive emotions have a profound effect on wellbeing (Jantos & Kiat, 2007). Prayer is well known as a channel for supernatural intervention – people pray for help from the divine, they pray for miracles.

Prayer is a mechanism that has good physiological side effects as described above and it also works to contribute to health in a way that science cannot measure. People may use all or some of these prayers at different times in their lives in response to perceived needs. Prayer, as noted earlier, may include spiritual healing, meditation, chanting and can be done in groups, singly, in places of worship or silently in a public place. A practitioner may not know if their patient is praying for wellbeing. There is debate in the literature about the efficacy of prayer as a means of achieving wellbeing (Dossey, 1993; Jantos & Kiat, 2007; L. Roberts, Ahmed, Hall, & Sargent, 2000). It is commonly noted that it is difficult to assess and measure. Theologians report that God cannot be measured nor does this divine power work to experimental controls.

Prayer as an element of faith is significant for many in regards to their health. A major study in a cardiac care unit in a southern Baptist hospital in the USA reported on a randomised controlled trial on the effect of intercessory prayer (Byrd, 1988). In the trial 393 patients were randomly allocated into two groups, one was prayed for and one was not. The results showed that the prayed-for group had improved health outcomes. They did not miraculously recover, but they had reduced use of diuretics and antibiotics, reduced incidence of pneumonia and intubations, less incidence of congestive heart failure, and less cardiopulmonary arrest. The report from the trial generated a great deal of debate in the literature as people grappled with the concept of prayer and the possibility of it having impact on health. A follow-up study called the Study of the Therapeutic Effects of Intercessory Prayer (STEP) investigated intercessory prayer on cardiac bypass patients (Benson, et al., 2006). This was a $2.4 million study conducted over nine years. The trial showed that the prayed-for group had more complications. There was discussion that the methodology for the trial might have been flawed since it was the patients who knew they were being prayed for, whose health was not as good at the end of the trial. This led researchers to conjecture if the knowledge they were
being prayer for induced a sort of performance anxiety or a dread that they were so ill they needed divine intervention.

Methodology in trials about prayer is problematic. Roberts et al., point out that the trials could well be contaminated because prayer can be done by anyone anytime and even though a randomised controlled trial group may be being studied, a trial cannot control devout believers of any faith who pray generally for those who are ill (K. Roberts & Taylor, 2002). Similarly, they comment that if God is omnipotent He or She may be noncompliant with the concealment process of a random controlled trial. The studies generated controversy as academics, theologians and researchers argued about the mechanisms for measuring the success of prayer as an aid to healing and to wellbeing. Other studies have been undertaken as a means of trying to understand the influence of prayer on health. Researchers note that the effect of prayer may be something other than measurable and identifiable health outcomes. It may contribute to a state such as coming to terms with a painful situation or a gaining of insight into the meaning of distress, or it may have no impact. They argue that prayer is difficult to measure but worthy of further research.

Prayer may involve the practice of laying-on of hands. This, as a religious/spiritual practice, is different from the ‘new age’ practices of reiki or energetic healing, as it is considered a sacrament of healing however it would seem reasonable to assume they work on similar principles. There is a stilling of the body, a focusing on the mind, a prayer or affirmation and purportedly a transmission of energy through the palms of the hands.

Alcoholics Anonymous uses the Serenity Prayer to offer consolation and guidance to its member. The prayer asks for “the serenity to accept the things that cannot be changed, the courage to change the things that can be changed and the wisdom to know the difference” it is recited at the end of every AA meeting to inspire people. The Lord’s Prayer is another example of an often-used prayer of significance and solace to Christian populations.
Appendix 9:
Reflective practices

The style of pedagogical approach used is critical in instilling rich deep learning in students. The opportunity to develop reflective thought is seen as a critical development stage, with Chickering et al. noting that contemplation is a cerebral metabolism and that the learning cycle necessarily involves this step as part of the process of integration into one’s thinking processes and the formation of beliefs (Chickering & Dalton, 2006). These opportunities do not exist in an education system where there is no opportunity for reflective time, as happens on retreats. The omission overlooks the fact that time for reflection is a deep, long-lasting investment in the maturation of the professional.

Developments in the structure of society have contributed to this shift with the tools of communication becoming highly technologised and plentiful so that it is relatively easy to avoid reflection and harder to achieve solitude and quiet. In health care practice diagnostic machines and computer-driven information technology are the tools of expression, test results and email are the carriers of information. When technology dominates the social exchange it means that an important element is lost. The loss lessens not only the quality and depth of human interaction but also diminishes the synthesis that happens in communication. This loss strikes at the heart of a bonded society.

Consider the vital role of self-understanding. This is critical in the development of human beings and it is particularly needed in our health care practitioners, as these are people with whom we trust the intimate workings of our bodies and our psyches. We want competence, but we also want human connection and depth of understanding in the vital relationship of health care. For a practitioner, understanding the self is the key to understanding and empathy with others. Self-knowledge is something that develops over time, but can also be purposefully fostered by meaningful education that extends beyond creating technical expertise and competence. Education aims to create practitioners, who treat holistically, are technically competent and carry within them an awareness of the spiritual needs of their patients.
Within health care practitioners it is the quiet voice that guides and retrieves information less available and ultimately more valuable. Reflective work is a highly valuable tool in becoming an effective health care practitioner. Philosophical subjects develop reflection in students and require a style of teaching different from the information dump and recall system. In this regard the Australian author Tacey suggests that the education relationship is different and the process is not so much about filling the students up with knowledge but encouraging remembrance (Tacey, 2005). When teaching about spirituality the teacher can call upon the interiority of the students, drawing out the deep knowledge that lies within and to do this the teacher needs to be less of an authority figure and more of a guide. In developing the philosophical mind there is a seeking of a deeper kind of innate intelligence (Tacey, 2005). Tacey goes so far as to suggest that teachers need to consider receiving wisdom from their own hearts and from the hearts of their students for a real educational exchange to take place. Yet, as Chickering at al. (2006) point out, when institutions neglect the development of the student ‘interior’ in the structure and focus of their lecturer programs, this has deep implications for the future of society and for our communities and the world (Chickering & Dalton, 2006). The culture and values of education and training reflect a shift in external culture, whereby recognition of the value and importance of meaningful life has been replaced by desire and motivation for a financially secure life and it appears this is happening in natural medicine as well. Chickering et al. argue that the spiritual interior has been replaced by the material exterior in the work of higher education (Chickering & Dalton, 2006). The shift is reflected in curricula that omit spirituality as part of the health paradigm and not training students in this component of health works to change the meaning of holism in the profession.

The curriculum and the delivery are equally important. The impact of one relies on the effectiveness of the other. The problem is apparent at an educational level where there is no time for reflection. This is where the neophytes are inducted in the profession and learn key values and beliefs; accordingly content and delivery are critical components to the process. The science subjects may be perceived as heavy going but sound knowledge is a base line for good practice. Delivery of these important tools requires skill and intelligence on the part of the educator. Overall curriculum design can be measured to take in student need and development. When high cost activities such as retreats, workshops and tutorials disappear, are minimised or are made optional to students for extra cost then the goals change in subtle, persistent ways. Ignoring the intellectual and moral development of students at the expense of
completing the goals of a course in a timely and economic fashion is to pretend that students are empty vessels devoid of thought and feeling. This education style furthers the mechanistic drive of biomedicine and misses the opportunity to foster health care practitioners rich in spirit and heart.
## Appendix 10: Program outlines

### Schedule of units

#### Bachelor of Naturopathy SCU

**4.1 Requirements for an Award**

To be eligible for the award of the Bachelor of Naturopathy, a candidate shall successfully complete not less than thirty-two (32) units comprising:

a. All units in Part A of the Schedule of Units; and

b. four (4) elective units, two (2) which must be from Part B of the Schedule, or other approved units

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<td>HEA10063 - Care of the Older Person I</td>
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<td>HEA10200 - Trans- and Intergenerational Trauma</td>
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<td>HEA10201 - The Biological Effects of Traumatic Stress</td>
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<td>HEA10202 - The Story of Healing/Indigenous Healing</td>
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### HLT10117 - Advanced Therapeutic Massage: Myofascial Techniques
- MAT00330 - Research and Analysis in Health
- MNG00301 - Sport Management Principles
- MNG00314 - Entrepreneurship
- NUT00333 - Sport and Exercise Nutrition
- PHA00315 - Introductory Pharmacology
- SOY00419 - Caring for Kuntri: Indigenous Environmental Management

### Nature Care College of Natural Therapies

#### Advanced Diploma of Naturopathy subject list

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### Advanced Diploma of Naturopathy

**Units of competency**

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# Endeavour College of Natural Health

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### Year Four: Semester Eight

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## Course Structure - Western Australia Campus only

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**Electives**

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### Southern School of Natural Therapies

**First Year Semester 1**

- Anatomy and Physiology 1 [BL103] 56 hrs
- Biomedical Study Skills [RS110] 28 hrs
- Bioscience 1 [BL110] 31 hrs
- Clinical Nutrition 1A (Dietary nutrients and human health) [NM104] 31 hrs
- Naturopathic Herbal Medicine 1A (Botany) [NM102] 31 hrs
- POSACOM - Philosophy of science and complimentary medicine [RS120] 28 hrs

**Semester 2**

- Anatomy and Physiology 2 [BL104] 56 hrs
- Bioscience 2 [BL111] 31 hrs
- Clinical Nutrition 1B (Dietary nutrients and human health) [NM105] 31 hrs
- Human Ecology [BL105] 28 hrs
- Naturopathic Herbal Medicine 1b (Manufacturing) [NM103] 28 hrs
- POSACOM - Philosophy of science and complimentary medicine [RS120] 28 hrs

**Second Year Semester 1**

- Anatomy and Physiology 3 [BL202] 68 hrs
- Iridology 1 (Iris diagnosis) [NM210] 31 hrs
- Naturopathic Clinical Nutrition 2A (Food law, food science and supplements) [NM206] 31 hrs
- Naturopathic Herbal Medicine 2A (Herbal materia medica) [NM204] 34 hrs
- Naturopathic Homoeopathy 1A (Acute prescribing & tissue salts) [NM208] 31 hrs
- Psychology 1 [SS204] 31 hrs
Appendix 10: Program outlines

Semester 2

Anatomy and Physiology 4 [BL203] 68 hrs
Biochemistry 2 [BL205] 34 hrs
Clinical Studies 1 (Internal Clinical Observation) [CS200] 23 hrs
Iridology 2 (Iris diagnosis) [NM211] 31 hrs
Naturopathic Clinical Nutrition 2B (Foods, diets and health) [NM207] 31 hrs
Naturopathic Herbal Medicine 2B (Herbal materia medica) [NM205] 34 hrs
Naturopathic Homoeopathy 1B (Acute prescribing and flower essences) [NM209] 31 hrs
Psychology 2 [SS205] 31 hrs
Research Methods [RS220] 28 hrs

Third Year Semester 1

Advanced Research Methods [RS310] 28 hrs
Clinical Studies 2 (External clinical experience) [CS300] 61 hrs
Counselling for Naturopathy 1 [SS302] 28 hrs
Naturopathic Clinical Medicine 1A (Naturopathic therapeutics) [NM308] 34 hrs
Naturopathic Clinical Nutrition 3A (Nutritional therapy & celloids) [NM304] 31 hrs
Naturopathic Herbal Medicine 2C (Herbal pharmacology) [NM310] 28 hrs
Naturopathic Homoeopathy 2A (Acute and chronic body system prescribing) [NM306] 31 hrs
Pathology 1A [BL302] 68 hrs

Semester 2

Clinical Diagnosis 1 [BL301] 56 hrs
Counselling for Naturopathy 2 [SS303] 28 hrs
First-Aid (can be done in either Semester 1 or 2) [BS105] 14 hrs
Naturopathic Clinical Medicine 1B (Naturopathic therapeutics) [NM309] 34 hrs
Naturopathic Clinical Nutrition 3B (Nutritional therapy) [NM305] 31 hrs
Naturopathic Homoeopathy 2B (Acute and chronic body system prescribing) [NM307] 31 hrs
Pathology 1B [BL303] 68 hrs

Fourth Year Semester 1

Clinical Diagnosis 2 [BL402] 56 hrs
Clinical Studies 3A (Clinic review tutorial) [CS404] 21 hrs
Clinical Studies 5A (Clinical practicum) [CS406] 66 hrs
Naturopathic Clinical Medicine 2A (Naturopathic therapeutics) [NM406] 28 hrs
Naturopathic Herbal Medicine 3A (Prescribing and formulae) [NM404] 34 hrs
Naturopathic Homoeopathy 3A (Classical and constitutional prescribing) [NM408] 28 hrs
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<td>Practice Establishment [CS401]</td>
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