

Complementary and alternative medicine

RESearch and royals, patients and politicians, counsellors and clinicians – all have recently taken a considerable interest in complementary and alternative medicine (CAM). Fringe, unconventional, unorthodox, natural and folk medicine have come in from the cold, and CAM is now big business under this new label (Ernst & Furnham, 2000). CAM seems to be favourably perceived by many general practitioners (Easthope *et al.*, 2000). Indeed the rise of CAM has led to a House of Lords inquiry into six aspects of CAM: evidence, information, research, training, regulation and risk, and NHS provision (Ernst, 2000).

In recent years the increasing public interest in CAM (see box opposite) has been reflected in academic books (e.g. Abbot *et al.*, 1996; Vincent & Furnham, 1999) and journal articles (e.g. the 'theme issue' of the *Journal of the American Medical Association*, 1998, 280, No.18). So what answers has this research provided? Why is CAM so popular? Does it actually work? And what role can psychology play in understanding the phenomenon?

Unity and diversity in CAM

Aakster (1986) described three main models of medical thinking. The *pharmaceutical* model is a demonstrable deviation of function or structure that can be diagnosed by careful observation. The causes of disease are mainly germ-like, and the application of therapeutic technology is all-important. The *integrational* model resulted from technicians attempting to 'reintegrate' the body. This approach is not afraid of allowing for psychological and



ADRIAN FURNHAM on the role of psychology in understanding the dramatic rise of alternative therapies.

social causes to be specified in the aetiology of illness. The third model has been labelled *holistic* and does not distinguish between soma, psyche and social. It stresses total therapy and holds up the idea of a natural way of living.

The wide scope of CAM makes it difficult to pigeonhole within one of these models, or to identify what unites CAM in the face of the considerable diversity of theories, philosophies and therapies. Yet there *are* common themes within the philosophies of CAM. Aakster (1986) believes that they differ from orthodox medicine in five ways:

- **Health:** Whereas conventional medicine sees health as an absence of disease, alternative medicine frequently mentions a balance of opposing forces (both external and internal).
- **Disease:** The conventional medicinal interpretation sees disease as a specific, locally defined deviation in organ or tissue structure. CAM practitioners stress wide signs, such as body language indicating disruptive forces and restorative processes.
- **Diagnosis:** Regular medicine stresses morphological classification based on location and aetiology, while alternative interpretations often consider problems of functionality (e.g. in dressing or feeding oneself) as diagnostically useful.

- **Therapy:** Conventional medicine often claims to destroy, demolish or suppress the forces that make people ill, while alternative therapies often aim to strengthen the vitalising, health-promoting forces. CAM therapies seem particularly hostile to chemical therapies and surgery.
- **Patient:** In much conventional medicine the patient is the passive recipient of external solutions – in CAM the patient is an active participant in regaining health.

One way of classifying the many different CAM therapies is by 'emphasis' (structural, biochemical, energetic and mind-spirit) and by their methods of care and treatment (Turner, 1998). Using factor analysis, I set out to see how 589 members of the public classified 39 different types of CAM, depending on whether they had heard of it, knew how it works, whether they had tried it, and whether they believed it works or not (Furnham, 2000). A pattern emerged with art therapies (e.g. music, dance), talk therapies (i.e. counselling), and 'foreign techniques' (e.g. Reiki, Shiatsu) all classified distinctly. The 'big six' therapies – acupuncture, chiropractic, homoeopathy, medical herbalism, naturopathy (a belief in the healing power of nature) and osteopathy – are often grouped together by lay people, presumably because they see them as most established and regulated – despite the fact they are based on very different methods and philosophies.

In fact it is this diversity in the field of CAM that can lead to problems in regulation. While there have been calls to find regulatory bodies to oversee all CAM practices, this has proved very difficult because of the theoretical, historical and political differences between the various

WEBLINKS

Research Council for Complementary Medicine: www.rccm.org.uk

National Center for Complementary and Alternative Medicine: www.nccam.nih.gov

Institute for Complementary Medicine: www.icmedicine.co.uk

Complementary Medical Association: www.the-cma.org.uk

House of Lords Science and Technology Report: www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm

CAM specialities. Given this lack of an official regulatory body, scientific research into the effectiveness of CAM becomes even more crucial.

Fortunately, the popular interest in CAM has indeed been matched by a relatively sudden and dramatic increase in research on the two central questions in this area: do CAM therapies actually work, and why do people choose them?

Does it work?

Is there good evidence from double-blind, placebo-controlled, randomised studies that a particular therapy 'cures illness' as it says it does? Properly designed and executed studies are complex and very expensive, and similar to the research effort to determine the efficacy of psychotherapy. Indeed, it is the extensive research into the placebo effect that makes psychological input particularly valuable (Vincent & Furnham, 1997).

The answer to the question is either very little or no good evidence is available for the therapeutic success of most CAM, possibly with the exception of herbalism (Vincent & Furnham, 1999). This is because there has not been a concerted scientific research effort to investigate the claims of many of the specialities of CAM until recently. However, as more sophisticated meta-analyses are published it does seem to be the case that there is clear, incontrovertible evidence for small but robust positive effects of specific CAM treatments (e.g. Ernst & Pittler, 1998).

Why choose it?

If the evidence is limited and equivocal, and indeed often points to lack of

THE RISE AND RISE OF CAM

USA

- In 1993, 34 per cent of the population visited a CAM therapist, more than visited primary care physicians. Expenditure was estimated at \$13.7 billion a year (Eisenberg *et al.*, 1993).
- By 1998, 47.3 per cent of all Americans were estimated to visit a CAM practitioner: annual visits rose from 427 million in 1990 to 629 million in 1997 (Eisenberg *et al.*, 1998).

France

- Use of homoeopathy (the most popular CAM) rose from 16 per cent of the population in 1982 to 29 per cent in 1987, and to 36 per cent in 1992 (Fisher & Ward, 1994).

The Netherlands

- In 1981, 6.4 per cent visited a CAM therapist – rising to 15.7 per cent in 1990 (Fisher & Ward, 1994).

UK

- Around 25 per cent of the British population have used some form of CAM.
- Around 80 per cent of the public who use it are satisfied with CAM therapies compared with 60 per cent with 'orthodox medicine'.
- Around 65 per cent of British hospital doctors believe that CAM has a place in mainstream medicine.
- About 93 per cent of GPs have suggested a referral to CAM (Ernst & Kaptchuk, 1996).
- Nearly 67 per cent of local health authorities in the UK are purchasing at least one form of CAM (White & Ernst, 2000).
- Individuals spend £1.6 million per annum on CAM therapies, the NHS about £40 million; and £500 million is spent on CAM products (Ernst & Furnham, 2000).

efficiency, the central question must be why patients choose (at their own expense) to visit a CAM practitioner. What do they get from the treatment? Why do they persist? This is where there have been many psychological studies (Furnham & Kirkcaldy, 1996; Vincent & Furnham, 1999) concerning the often mixed motives that patients have in shopping for health treatments. Results from various studies (reported by Vincent & Furnham, 1997) show several key factors.

People shop for health They want to use all possible (and affordable) options in health care. People are not 'brand loyal' to orthodox medicine or any particular therapy. They experiment, and CAM is to many just another product or service. The

question is how the brand offers something quite different that no other product service offers. This raises the question – as yet to be answered – of what makes an individual brand loyal to a therapy, a therapist or indeed a place of treatment.

People want a cure without side-effects or pain This may in fact distinguish different CAM therapies, offering a very strong, unique selling point for homoeopathy over either herbalism or acupuncture, because of the scare stories about poisoning in the former and pain and infection in the latter. It is for instance the 'gentleness' of homoeopathy and its dilutions that may be particularly attractive to people.

CAM is seen as a 'last hope' for chronic illnesses Many sufferers of chronic painful conditions or addictions have tried many other cures, and turn to CAM as a last hope. Some treatments have a powerful psychological component particularly those associated with touch (i.e. massage, reflexology). Equally the emphasis may need to move from cure to effective management of such chronic conditions, just as it does in clinical psychology.

Disappointment with the traditional orthodox consultation GPs all too often have little time, may seem patronising, or may not fully examine the patient or touch them. Further, patients are often not asked the full set of questions they expect to answer for a 'full' diagnosis. In short, they are not treated like a modern

adult consumer. There is a strong departure point for many CAM practitioners who have much longer consultations, and appreciate patients' need to talk or be examined. The question is how the traditional or average CAM consultation is different from both traditional orthodox consultation and that of other (competitor) CAM therapies. It is possible to compare and contrast across a number of variables (history-taking approach, language used, patient role, decision-making process, bedside manner) to show how different they are, which may account for the popularity of CAM.

People want an emphasis on

'wellness', not 'illness' Because many people want to learn more about self-care, fitness (wellness and preventive measures) orthodox medicine may be seen as a narrow, restorative, disease- (complaint-) oriented approach that aims to destroy, demolish or suppress illness-inducing forces through such things as chemical therapies and surgery. What many people want is an emphasis on natural restorative processes. The emphasis is quite different – illness vs. wellness. Psychologists have long recognised this as a valid and useful approach. CAM is often seen as restorative,

balanced, natural and preventive, fitting in with the particular zeitgeist.

Many people believe in the 'holistic' message

It seems obvious to most that lifestyle, personal relationships and work operate all together and simultaneously have an impact on health. Equally they believe that there are many and manifold signs of wellness and illness from digestion, sleep patterns and body appearance to more subtle nonverbal signs

associated with gait, balance, body odour, and so on. The implication is that the diagnostic interview may need to include questions about all aspects of the person's life, not only their physical symptoms.

Is there a CAM 'type'?

Comparisons of users and non-users of CAM have shown evidence of different beliefs about health and disease in general (Vincent & Furnham, 1997). There is some evidence that frequent CAM users are more health conscious and believe more strongly that people can influence their own state of health, both by lifestyle and through maintaining a psychological equilibrium. Users of CAM appear to have less faith in 'provider control' – the ability of medicine (specifically orthodox doctors) to resolve problems of ill health. Some studies of cancer patients using CAM have found that they were more likely than those not using CAM to believe cancer was preventable through diet, stress reduction and environmental changes and to believe that patients should take an active role in their own health (Cassileth, 1988).

Many CAM users seem to be sympathetic with green issues, ideas and understanding. These include environmentalism, anti-materialism and a belief in 'one world'. Pro-CAM beliefs may also include issues around inequality, alienation, and social exclusion. CAM patients also seem to be interested in general consumer affair issues and may even belong to bodies that attempt to lobby in favour of a certain position. They appear to be sensitive to consumer rights, bad practice and poor treatment. CAM patients appear to be particularly interested in the 'life of the mind'. They certainly believe the maxim of 'a healthy mind and a healthy body'. CAM patients are, because of their own medical condition, likely to be very empathic to the plight of others, and hostile to the 'uncaring' attitude of certain specialists (e.g. surgeons). However, despite these suggested differences in beliefs and values, there is little to support the widely held view that those who use CAM are especially gullible or naive, or have unusual (neurotic) personalities or bizarre values or belief systems.

In terms of demography, those who use CAM are more likely to be women, aged 30–40, middle rather than working class, educated above average levels, and to live in urban rather than rural areas. Their medical history is more likely to feature chronic problems than acute, often non-specific or with a heavy psychological (i.e.

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non physical) component. Many patients have a 'thick file' in the sense that their interest in health issues has led them to seek out various remedies from many different sources.

However, despite some differences in beliefs, it is dangerous and foolhardy to talk about the 'typical' user. CAM rejoices in differences and individuality and the uniqueness of people's lives.

The role of psychology in CAM research

Psychological research can substantially help medical and sociological research into CAM through both methodological and theoretical contributions.

Psychologists' expertise in evaluative research and methodology, their understanding of placebo effects and their emphasis on evidence-based methodology means that they are ideally suited to join multidisciplinary research teams interested in CAM. More sophisticated, longitudinal research is needed to explore differences in orthodox medicine and CAM patients. Further, key elements in the CAM consultation that make them popular,

including the explanations that they provide, merits good research. Social psychological expertise in questionnaire design and analysis, as well as discourse analysis, can be (and indeed has been) very useful in trying to understand patient motives and satisfactions. Research psychologists interested in experimental design and meta-analysis may assist in evaluating the quality of the experimental evidence, as well as assist CAM practitioners and less experienced research design studies so as to reduce artefacts and confounds. Recent studies on efficacy research into psychotherapy, perhaps even harder to evaluate than CAM therapies, has helped psychologists address some of the issues concerned with evaluating the ingredients of therapeutic efficacy (Bergin & Garfield, 1994).

From a theoretical perspective psychology may be particularly useful in helping understand patient pathways to CAM; the knowledge, attitudes and beliefs of patients as well as the dynamics of the GP and CAM consultation. Indeed this knowledge may prevent the growth of CAP – complementary and alternative

psychotherapy – with all the associated problems of unregulated practitioners of very dubious practices.

Psychological theories may also be applied to, and tested in, the CAM context. Thus Furnham and Lovett (2001) showed the theories of reasoned action and the theory of planned behaviour could be used successfully to investigate factors underlying intentions and actual use of homoeopathy over a one-month period. Similarly, Furnham and Lovett (in press) demonstrated how attribution theory could understand patient perceptions of risk. There are many other psychological theories and models in the health and medical psychology literature (e.g. the health beliefs model) that may go a long way to answering some of the fundamental questions in this comparatively new, multidisciplinary area of research. Psychology and CAM may have a healthy and fruitful relationship for many years to come.

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