The psychology of complementary and alternative medicine

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Abstract: This paper attempts to answer the question: What accounts for the universal rise in interest in complementary and alternative medicine (CAM), the growth of practitioners and potential patients seeking them out? It is recognised that there is great diversity both within CAM (in terms of philosophy, methodology, research) as well as between CAM and orthodox medicine. The limited empirical research concerning why people choose a CAM practitioner is reviewed. Six major reasons are given to answer the above question recognising their relationships to one another and that other reasons do exist. There is no typical patient, although the results do suggest that certain individuals based on their demography, medical history and belief system are most likely to choose CAM.

Keywords: choice, treatment, research, reasons, diversity

The dramatic rise of CAM

Many have recently taken a considerable interest in what is now called complementary and alternative medicine (CAM) (Table 1). Fringe, unconventional, unorthodox, natural folk medicine has become what is now big business under this new label (Ernst and Kaptchuk 1996; Ernst 1997; Furnham 1999; Ernst and Furnham 2000). CAM seems to be favourably perceived by many general practitioners (GPs) (Easthope et al 2000). Indeed the rise of CAM has led to a House of Lords enquiry into six aspects of CAM: evidence, information, research, training, regulation and risk, and National Health Service (NHS) provision (Ernst 2000).

There is considerable rise in public and research interest in complementary medicine (Abbot et al 1996; Vincent and Furnham 1999). One index of this is the ‘theme issue’ of the Journal of the American Medical Association 1998, 280(18).

The statistics on the use of CAM are impressive. Consider the following examples:

• America: By 1998, 47.3% of all Americans were estimated to visit a CAM practitioner. Annual visits rose from 427 million 1990 to 629 million in 1997 (Eisenberg et al 1998).
• France: Use of homeopathy (the most popular CAM) rose from 16% of the population in 1982, 29% in 1987, to 36% in 1992 (Fisher and Ward 1994).
• Germany: Two billion euros were spent on herbal medications in 2000, about 10% of which was on drug sales.

Many are dismayed by this rise, while for others it is good news. Practitioners of Western, orthodox medicine often seem dismayed by the above statistics and unable to explain why there has been a mass exodus to areas of CAM where there is little or no evidence - based science. Sociologists on the other hand have tried to describe the reasons why this ‘flight from science’ has occurred across the developed world (Furnham and Vincent 2000, 2001).

Diversity and unity in the CAM therapies

The great range of varieties of CAM inevitably means there is a considerable diversity of theories, philosophies and therapies. Yet there are common themes in the philosophies of CAM. Aakster (1986) believes that they differ from orthodox medicine in terms of five things:

• 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/ or restorative processes.
Table 1 Indices of the growth of interest in CAM

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<th>America</th>
<th>France</th>
<th>The Netherlands</th>
<th>United Kingdom</th>
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<td>In 1993, 34% of all Americans visited a CAM therapist, more than visits to all US primary care physicians put together. Expenditure was estimated at US$13.7 billion per annum (Eisenberg et al 1993).</td>
<td>Use of homeopathy (the most popular CAM) rose from 16% of the population in 1982, 29% in 1987, to 36% in 1992 (Fisher and Ward 1994).</td>
<td>6.4% attended a CAM therapist in 1981, rising to 9.1% in 1985 and 15.7% in 1990.</td>
<td>Around 25% of the British population have used some form of CAM.</td>
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<td>By 1998, 47.3% 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).</td>
<td>Around 80% of the public are satisfied with CAM therapies compared with 60% for orthodox medicine.</td>
<td>Around 65% of the British hospital doctors believe that CAM has a place in mainstream medicine.</td>
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<td>Alternative interpretations often consider problems of functionality to be diagnostically useful.</td>
<td>About 93% of GPs have suggested a referral to CAM.</td>
<td>Nearly 67% of local health authorities in the UK are purchasing at least one form of CAM (White and Ernst 2000), about half of whom have any formal training in any CAM speciality.</td>
<td>Individuals spend £1.6 million per annum on CAM therapies, the NHS about £40 and £500 million is spent on products (Ernst and Furnham 2000; White and Ernst 2000).</td>
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- Diagnosis: Regular medicine stresses morphological classification based on location and aetiology, while alternative interpretations often consider problems of functionality to be diagnostically useful.
- Therapy: Conventional medicine often claims to destroy, demolish or suppress the sickening forces, 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 while in CAM the patient is an active participant in regaining health. 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 social causes to be specified in the aetiology of illness.

The third model had 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.

Turner (1998) believed all CAM therapies could be classified first by ‘emphasis’ (structural, biochemical, energetic and mind-spirit) but also by their care systems. Furnham (2000) used factor analysis to see how the public (n = 589) classify 39 different types of CAM on whether they had heard of it, know how it works, whether they had tried it and whether they believe it works or not. A pattern emerged with art therapies (eg music, dance), talk therapies (ie counselling) and ‘foreign techniques’ (eg reiki, shiatsu). The ‘big six’ most established therapies (acupuncture, chiropractic, homeopathy, medical herbalism, naturopathy and osteopathy) are often grouped together by lay people presumably because they see them as most established and regulated despite the fact that they are based on very different methods and philosophies.

Gray (1998) argued there are currently four quite different perspectives on complementary medicine:

1. The biomedical perspective. This is concerned with curing disease and control of symptoms where the physician–scientist is a technician applying high-level skills to psychological problems. This perspective asserts: (1) that the natural order is autonomous from human consciousness, culture, morality, psychology and the supernatural; (2) that truth or reality resides in the accurate explanation of material (as opposed to spiritual, psychological or political) reality; (3) that the individual is the social unit of primary importance (as opposed to society); and (4) that a dualistic framework (eg mind/body) is most appropriate for describing reality. This approach is antagonistic toward and sceptical of CAM, believing many claims to be fraudulent and many practitioners unscrupulous.

2. The complementary perspective. Though extremely varied, those with this perspective do share certain fundamental assumptions: (1) believing in the importance of domains other than ‘the physical’ for understanding health; (2) viewing diseases as symptomatic of underlying systematic problems; (3) a reliance on clinical experience to guide practice; and (4) a cogent critique of the limits of the biomedical approach. Interventions at the psychological, social and spiritual level are all thought to be relevant and important, supporting the idea of a biopsychosocial model. Many advocates are critical of biomedicine’s harsh and