Introduction

Complementary and alternative medicine (CAM) refers to a diverse range of therapeutic practices and systems of healing that are primarily defined by their relationship (or opposition) to mainstream conventional medicine. For example, the Cochrane Collaboration define CAM as ‘a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period’ (Zollman and Vickers, 1999). Originally, ‘alternative medicine’ was used to define therapeutic approaches that were incompatible with and replaced conventional medicine, but over time, the definition has broadened as many therapies and systems of healing are seen to ‘complement’ rather than oppose conventional medical care. Defining CAM is an inherently complex process, since it incorporates such a wide range of therapies (from complete systems of healing such as Traditional Chinese Medicine (TCM) to over-the-counter herbal remedies) and what is considered to be CAM changes as some modalities become absorbed into mainstream practice and new therapies emerge.

Irrespective of definitional issues, it is generally agreed that CAM use is increasing exponentially in western countries. This raises a number of issues central to health psychology. What are the explanations for the trend towards more pluralistic healthcare? What does it tell us about patients’ expectations and health needs? What are the implications for patients’ experiences of illness and treatment, both allopathic and complementary?
Psychological research remains relatively limited in this multi-disciplinary field, predominantly focusing on the reasons why people turn to CAM and psychological aspects of the treatment. However, many of the theoretical approaches within psychology can be applied to this area to better understand the motivations underlying people’s treatment decisions as well as attitudes within orthodox medicine. In order to understand the context of changes in health care decision making, we can also draw on anthropological and sociological data to understand the impact of wider social and cultural factors on our beliefs about health, and the relationship between CAM and established orthodox systems.

The relationship between complementary and orthodox medicine

The fundamental approaches of complementary and conventional medicine are frequently contrasted, in which the former is seen to adopt a biopsychosocial approach, the latter a reductionist biomedical perspective. Although it includes a diverse spectrum of therapeutic systems, the discourse of complementary medicine emphasizes the health-promoting ability of the body and the importance of aligning physical, social and environmental factors in a holistic, integrative approach. In contrast, the biomedical model has traditionally focused on the treatment of disease and is highly interventionist, treating the individual parts of the body that are not functioning correctly. Critics of the biomedical model thus have argued that the patient has become increasingly marginalized from medicine through this ‘spatialization’ of illness (Foucault, 1976), which not only separates the person from their body but also disempowers the patient and discourages their active participation. Parallels can be drawn with Mischler’s discussion of the struggle between the ‘voice of lifeworld’ and the ‘voice of medicine’ in the medical consultation, causing fragmentation and ineffective communication:

the voice of the lifeworld refers to the patient’s contextually-grounded experiences of events and problems in her life . . . In contrast the voice of medicine reflects a technical interest and expresses a ‘scientific attitude’. (1984, p. 104)

Certainly there is evidence from the satisfaction literature that patients want more personal relationships with their practitioners and greater attention placed on psychosocial issues (Bertakis et al., 1991; Greene et al., 1994). In CAM consultations, particularly during initial history taking, greater time and attention is given over to the context of the patient’s illness and life history. It has therefore been suggested that this greater congruency with the patient’s lifeworld is one reason why people are increasingly turning to complementary health care (Busby, 1999).
‘Holism’ is another well-used term to characterize complementary therapies and differentiate them from the reductionism of conventional medicine. Indeed, the holistic nature of CAM is frequently cited by users of CAM as an important component of their experience of the treatment process, both in terms of uncovering and explaining causal patterns and in treating illness using a range of strategies (Gould and MacPherson, 2001; Paterson, 2004; Richardson, 2004; Cartwright and Torr, 2005). However, there is some debate about the meaning of ‘holistic’ and the extent to which it can be applied to any therapeutic approach. ‘Holistic’ is defined as diagnosing and treating the individual within their wider environment, using complex interventions and involving the patient in the treatment process (Pietroni, 1987). Thus, despite the strong association between holistic practice and CAM, holism is the goal of all therapeutic practice. As Fulder (2005, p. 775) points out, ‘the holistic approach is simply good medicine, and it cuts across all modalities and techniques, whether alternative or conventional’.

Indeed, we must be wary of an overly simplistic view of biomedicine. Sharma (2000, p. 214) argues that biomedicine is not ‘the monolithic entity which it so often appears to be from the perspective of patients’. She suggests that we understand the recent rise of CAM within the context of a ‘wider web of relationships’ characterized by medical pluralism. Several theorists link such pluralistic practice with the fragmentation indicative of post-modernism. For example, Bakx (1991) argues that the increasing separation and alienation of consumers from biomedicine has resulted in a new culture of medical pluralism in which conventional medicine is losing its ideological hegemony while complementary and folk therapies thrive. The failure of medicine to reflect wider cultural shifts has resulted in it becoming ‘politically and culturally out of “synch” with a growing section of the population’ (1991, p. 25). However, in the majority of cases, orthodox or allopathic medicine is not rejected but rather supplemented with complementary healthcare (Eisenberg et al., 1993; Astin, 1998; Thomas, Nicholl, and Coleman, 2001).

A change in attitudes towards health and illness has certainly been linked with the increasingly consumerist health culture prevalent in the West. For example, Kelner and Wellman (1997) argue that the popularity of CAM reflects the increase in ‘smart consumers’ who are more proactive and informed in health matters. The majority of studies have shown that users of CAM meet their health needs by ‘shopping around’ for treatments and using both orthodox and complementary medicine (Sharma, 1994). Indeed, health information is more widely available through the internet, media and illness-specific support groups encouraging greater involvement in one’s health. Such shifts are also evident within medicine, with increasing attention on patient-centred care and patient participation, particularly in the area of chronic illness. In the UK, the Department of Health has invested £18 million in the expert patient education programme, which aims to help
100,000 people with chronic illnesses manage their conditions better through a lay-led self-management programme. This has been linked with a ‘new era of opportunity for the NHS’ (Donaldson, 2003, p. 1279), although findings regarding its success are mixed (Griffiths et al. 2007).

The meaning of health and illness: lay beliefs

Research into people’s beliefs about health and illness and their relationship to behaviour is a key focus of health psychology and one which overlaps with the related disciplines of medical sociology and anthropology. Our conceptions of health and illness vary according to our socio-cultural background and are a strong determinant of our health-seeking behaviour. It has therefore been suggested that one explanation for the popularity of CAM lies in the congruence between patient and practitioner models of health and illness (e.g. Astin, 1998).

So how do people conceptualize their health? Studies show that lay beliefs about health are multi-faceted, reflecting medical (absence of disease), psychological (vitality and well-being), and social perspectives (social relationships) (Blaxter, 1990). Herzlich’s (1973) classic study of lay beliefs in France highlighted the importance of harmony or balance and capacity for activity. Such beliefs are congruent with the philosophy and language of CAM, users of which are predominantly from the middle classes, like the majority of Herzlich’s sample. A more recent review of qualitative studies exploring perceptions of health and illness revealed interesting class differences in beliefs (Chamberlain, 1997). While working-class people tended to see health in functional terms, namely the absence of disease and the ability to carry out daily activities, those of higher socio-economic status (SES) placed more emphasis on the positive qualities of health such as vitality and well-being. Chamberlain (1997) differentiated four further groups which represented differing views of health in terms of complexity and integration as well as reflecting broad socio-economic trends. The solitary view held by lower SES participants perceived health as purely physical while the dualistic view incorporated both physical and mental aspects but saw them as operating independently. The two remaining groups were predominantly of higher SES, in which the complementary view perceived mental and physical aspects as forming an integrated whole, while the multiple view saw health as an interdependent balance of physical, emotional, social and spiritual elements. Linking this with the use of CAM, it might be surmised that the integrated approach characteristic of most complementary therapies is particularly congruent with the beliefs of those from higher SES groups, who are also more able to purchase private CAM care.

Beliefs about underlying aetiology are also central to our understanding of health and illness. In a British Q-sort study, Stainton-Rogers (1991) found seven key explanations of health/illness, ranging from the biomedical
The context of health care decisions

Decisions concerning the treatment of illness are strongly influenced by our beliefs, prior experiences and availability of health care. Using a cross-cultural perspective, cognitive anthropologist Arthur Kleinman (1980) divides the health care system into three sectors: popular, folk, and professional. The balance and relationships between the sectors differ according to cultural norms and historical changes in beliefs and institutional power. The popular or lay sector is where illness is typically first defined and initial health care decisions made, such as whether to self-treat or refer to one of the other sectors. This non-specialist sector includes a broad range of sources, including friends and family, colleagues, church members and any other lay person with relevant illness experience. Studies in the UK suggest that the most symptoms are initially treated within this sector (Verbrugge and Ascione, 1989), and the majority of visits to both complementary and orthodox practitioners involve lay referral (Scambler et al., 1981; Sharma, 2001). The folk sector incorporates both sacred and secular healing and is characterized as non-bureaucratic and non-professional in contrast with the organized and regulated professional sector exemplified by the western medical system.

The positioning of complementary medicine in this typology is somewhat
problematic due to the great diversity of therapeutic modalities encompassed within the umbrella term ‘complementary and alternative medicine’. Thus, therapeutic systems that have formalized training and regulatory bodies (e.g. osteopathy, chiropractic, acupuncture and homeopathy) are more ‘professionalized’ than therapies without such formal guidelines and standards. Additionally, conventional medicine is not the dominant system in all cultures; in countries such as China, traditional Chinese medicine (TCM) is equally mainstream and institutionalized. Moreover, folk medicine is characterized as being embedded within a particular culture, yet many complementary therapies are not indigenous healing systems but rather relatively recent adoptions from other cultures. Clearly, there is considerable cross-over between the sectors and health care decisions are iterative, often involving movement between the different sectors, both to inform understanding of somatic symptoms and facilitate adequate treatment for the evolving illness experience.

Use of CAM

The increase in the popularity and use of CAM has been widely documented both in research and the media. Estimates of use vary according to the inclusiveness of the criteria used. For example whereas some studies focus solely on consultations with complementary practitioners (Thomas, Nicholl and Coleman, 2001), others include the use of over-the-counter remedies (Ernst and White, 2000). Additionally, surveys vary in the use of checklists of specific complementary therapies versus open questions which allow greater inclusivity of ‘fringe’ therapies. This lack of standardization in both the definitional umbrella of CAM and the study methodology makes temporal and cross-cultural comparisons problematic.

Two surveys have attempted to provide population estimates of CAM use in the UK population, postulating that between 20 and 28% of the population use CAM each year, when including both consultations and over-the-counter remedies (Ernst and White, 2000; Thomas, Nicholl and Coleman, 2001). In the BBC survey (Ernst and White, 2000), telephone interviews were conducted with 1204 randomly selected participants of which 20% reported using ‘any alternative or complementary medicines or therapies’ in the previous 12 months. The most popular therapies were herbalism, aromatherapy, homeopathy, acupuncture/acupressure, massage and reflexology. Based on average monthly estimates of spending, Ernst and White (2000) extrapolate that 1.6 billion is spent per year on complementary health care in the UK. The larger of the two studies favoured a narrower definition of CAM and focused primarily on consultations with practitioners of six of the more established therapies (acupuncture, chiropractic, homeopathy, hypnotherapy, medical herbalism, and osteopathy), with additional questions about two further therapies (reflexology and aromatherapy) and over-the-counter remedies (Thomas, Nicholl and Coleman, 2001). From 2669 respondents to
a postal questionnaire, they estimated that 10.6% of the population in England used one of the above six therapies in 1998, rising to 13.6% with the inclusion of the additional two therapies, and 28.3% with the inclusion of over-the-counter remedies. When lifetime use is considered, estimates increase to 46.6% using the most inclusive definition of CAM. From this data they extrapolate that 22 million visits were made to the six key therapies in 1998, at a cost of £450 million, since 90% of consultations are made outside the NHS. Comparisons with a pilot study conducted five years previously indicate an increase of around 2% in the number of CAM consultations per annum. A more recent Omnibus survey conducted in 2001 estimated that 10% of the population had used one of 23 named CAM therapies in the past 12 months, slightly lower than previous estimates (Thomas and Coleman, 2004). However, this may reflect differences in methodology and the fact that the survey was conducted across the UK rather than just England.

Figures of CAM use are similar or higher in the USA and Continental Europe where therapies such as homeopathy and acupuncture are often included in medical insurance. In the USA, it has been estimated that the number of consultations with complementary practitioners is higher than the number of visits to primary care physicians (Eisenberg et al., 1993). For comparison with the UK, Thomas, Fall and Nicholl (2001) estimated 1 CAM consultation for every 9 GP visits. Two large scale studies estimate that 40% of people use CAM each year in the USA (Astin, 1998; Eisenberg et al., 1998). However, the definition of ‘unconventional health care’ used in both studies was very broad to incorporate practices ‘neither taught widely in the U.S. medical schools nor generally available in U.S hospitals’, including megavitamins and lifestyle factors providing they were outside of standard medical care. Thus, such statistics are likely to over-estimate the usage of more narrowly defined complementary medicine. For example, a more recent large-scale US survey reported that 62% of adults had used some form of CAM in the previous 12 months, which dropped to 36% when prayer specifically for health reasons was excluded (Barnes et al., 2004). Eisenberg et al. (1998) noted a substantial increase in use from 33.8% in 1990 to 42.1% in 1997, again considerably higher than that estimated by Thomas, Fall and Nicholl (2001) in the UK, although this may largely reflect the measurement differences between the two studies.

Virtually all studies, irrespective of country and methodology, indicate that users of CAM are more likely to be female, younger, educated to a higher level, and of higher social class and income. This is likely to indicate differential access to CAM; those of higher income and education have greater access to information about health care options and the disposable income to afford private therapy. It has also been suggested that those from higher social groups are more likely to be self-directed and willing to explore non-conventional health care options as well as consuming all kinds of culture at higher rates (Kelner and Wellman, 2001). Unfortunately, this may
perpetuate health inequalities in which those from higher socio-economic
groups have access to a wider range of health resources. In terms of gender,
women are also higher users of allopathic primary care (Bradlow et al.,
1992) and it has been suggested that they are more likely to seek medical
care when suffering from psychological complaints (Verbrugge and Ascione,
1989; McIntyre et al., 1996).

Reasons for using CAM

Clearly the demand for CAM has increased substantially and much of the
psychological research has focused on delineating the factors associated
with CAM use. First, a number of studies have compared users of various
complementary therapies (generally homeopathy, acupuncture and oste-
opathy) with patients of conventional medicine to provide a ‘CAM user’
profile (e.g. Vincent and Furnham, 1997). Such studies indicate that com-
pared with patients of conventional medicine, CAM users are more critical
of orthodox medicine (Furnham and Smith, 1988; Furnham and Bhagrath,
1993; Furnham and Kirkcaldy, 1996; Vincent and Furnham, 1996), place
greater emphasis on psychological factors in illness (Furnham et al., 1995),
are more likely to have holistic health beliefs (Astin, 1998; Furnham and
Smith, 1988), and are more concerned with environmental issues and
preventative health practices (Furnham and Forey, 1994; Furnham et al.,
1995; Furnham and Kirkcaldy, 1996; Kelner and Wellman, 1997). These
findings are consistent with the argument that complementary therapies are
attractive because they are more congruent with patients’ philosophical and
health beliefs compared with the biomedical perspective (Furnham and
Beard, 1995; Vincent and Furnham, 1996; Astin, 1998). However, we
should be wary of treating all CAM users as a homogenous group with
similar health beliefs and attitudes (Furnham et al., 1995). There is evidence
that those seeking a more spiritual focus are more likely to choose less
mainstream therapies such as Reiki (Kelner & Wellman, 2001). While the
above surveys offer a descriptive profile of the typical user, they tell us
little about people’s underlying motivations to use CAM. Additionally, the
notion that CAM users are somehow ‘different’ from non-users is perhaps
less relevant as more people are using CAM.

A second related area of research has thus focused more specifically on
the reasons why people are choosing to use CAM. The findings from
such research are typically categorized into ‘push’ and ‘pull’ factors, namely
those factors which push people away from conventional medicine and
which attract people to look for alternatives (Vincent and Furnham, 1996).
For example, in a questionnaire study with 250 patients of acupuncture,
osteopathy and homeopathy, Vincent and Furnham (1996) identified
five factors describing reasons for using CAM: perceiving CAM as valuable,
perceiving conventional medicine as ineffective, concerns about the side-
effects of conventional medicine, poor doctor–patient communication in
conventional medicine, and the availability of CAM. Bishop et al. (2007) recently synthesized studies exploring beliefs associated with CAM use in a systematic review. They concluded that ‘CAM users want to participate in treatment decisions, are likely to have active coping styles and might believe that they can control their health.’ They value non-toxic, holistic approaches to health and hold “postmodern belief systems” while viewing themselves as unconventional and spiritual (2007, p. 862).

However, we also need to view the motivations for using CAM within the wider context of health needs and attitudes towards health care. First, concerns about conventional medicine are in part likely to reflect the greater prevalence of CAM use in people with chronic diseases (Vincent and Furnham, 1996; Kelner and Wellman, 1997; Eisenberg et al., 1998), which tend to be difficult to treat successfully within the orthodox medical system. Several studies have shown that users of CAM tend to have poorer health than non-users (Astin, 1998; Eisenberg et al., 1998; Sirois and Gick, 2002) suggesting a pragmatic use of CAM based on health need.

Decisions to seek alternatives to conventional care is frequently indicative of wider concerns with medical treatment, particularly regarding side-effects and worries about medication dependency (Conrad, 1985; Donovan and Blake, 1992; Horne, 1997; Horne et al., 1999). In developing a questionnaire to assess people’s beliefs about medicine, Horne et al. (1999) found that those attending a complementary medicine clinic (homeopath/herbalist) were more likely to perceive medicine as harmful and over-used than those presenting a prescription at a pharmacy. In-depth studies with users of CAM reflect these wider concerns over long-term medication and invasive treatments, whereas CAM is valued for providing ‘natural’ treatments that work in harmony with the body and which are therefore perceived as safer and more desirable (Sharma, 1994; Cartwright and Torr, 2005).

Additional attractions of CAM include the nature of the consultation itself (good communication, lengthy consultations, attention to psychosocial factors) and the role of the patient in the treatment process (greater autonomy and control over health, more patient-centred/egalitarian). It has been suggested that communication within medicine has lagged behind scientific developments, resulting in a lack of attention to the emotional needs of patients (Willison and Andrews, 2004). In contrast CAM provides longer consultations with in-depth history taking and highly individualized treatments. Additionally, a more collaborative and egalitarian relationship with the practitioner may be particularly attractive to those seeking a more proactive role in their health (Kelner and Wellman, 1997). The nature of the patient–practitioner relationship has received much attention within the literature of both complementary and conventional medicine, linking it with patient satisfaction, adherence to treatment recommendations and better health outcomes (Noble, 1998; Ong et al., 1995; Beck et al., 2002). Certainly a host of studies show that CAM users highly rate the therapeutic relationship and recognize the role it plays in the healing process (Luff
and Thomas, 2000; Sharma, 2001; Scott et al., 2003; Cartwright and Torr, 2005).

We have already considered the role of people’s beliefs in their care-seeking decisions. Astin (1998) found that concordance with spiritual and philosophical orientations was a more important predictor of CAM use than dissatisfaction with conventional medicine. Others have attempted to understand CAM use through the framework of post-modern values, arguing that the philosophy of CAM is consistent with cultural changes indicative of the post-modern era (Bakx, 1991; Siapush, 1999). Such attitudes have been characterized as: the rejection of authority, consumerism, individual responsibility for health (Coward, 1989; Bakx, 1991; Siapush, 1999) and also having a holistic outlook, viewing nature as benevolent and holding anti-science sentiments (Siapush, 1999). Two Australian studies have attempted to map such beliefs onto people’s attitudes towards and use of CAM, providing some support for the role of post-modern values in treatment choices and reinforcing previous research regarding the precedence given to ‘natural’ remedies (Siapush, 1998; Callaghan and Jordan, 2003). However, there is little evidence that people are sceptical of science (Siapush, 1999) nor that use of CAM is a ‘flight from science’; instead people are making treatment decisions on the basis of personal rather than institutional legitimacy (Haug and Lavin, 1983).

It seems likely that multiple factors, both pragmatic and ideological, influence initial and subsequent decisions to use complementary therapies and that the relative emphasis of these factors change over time. For example, dissatisfaction with conventional medicine is likely to be particularly salient in initial decisions to turn to CAM, while positive experiences with CAM are more important in subsequent motivations (Luff and Thomas, 2000; Sharma, 2001). Indeed, many of the ‘pull’ factors are experiential and emerge as individuals use alternative practices. Similarly, beliefs in holism and preferences for natural treatments may reflect individuals’ acceptance of beliefs represented by practitioners rather than ideological orientations towards CAM. Cross-sectional studies looking at CAM users at one point in time do not differentiate between types of user (e.g. committed or one-off) or indicate whether different health beliefs lead to health care choices or whether the treatment itself results in changes to patients’ beliefs and attitudes. For example, Yardley et al. (2001) observed reciprocal interactions between people’s illness and treatment beliefs and their experiences of chiropractic therapy and suggest that the therapeutic relationship plays a significant role in this process. Qualitative studies have been valuable in providing greater insight into this complexity and suggesting how the meaning of CAM changes over time. However, there is a need to explore motivations at different stages of CAM use and to follow up patients longitudinally.

Sirois and Gick (2002) attempted to distinguish between new/infrequent and established users of CAM, alongside non-users in a cross-sectional questionnaire study. Both the CAM groups reported more health-aware
behaviours, openness to new experiences and dissatisfaction with conventional medicine, which they suggest are important factors in initial treatment decisions. However, the best predictor of committed CAM use was health need (number of health problems). They interpret their findings using a socio-behavioural framework, which suggests that CAM use reflects three factors: predisposing (e.g. beliefs), enabling (e.g. financial resources) and need (e.g. health problems). Very few studies, however, have explored the process of using CAM longitudinally. One such study interviewed 23 new users of acupuncture on three occasions over a six-month period (Paterson and Britten, 2003). Their findings supported other single-account qualitative studies as to the evolving nature of CAM use (Sharma, 1992; Cassidy, 1998; Luff and Thomas, 2000; Gould and MacPherson, 2001). Dissatisfaction with conventional medicine was central to initial decisions, with other factors such as a desire for more holistic care and a concern with maintaining health and well-being, featuring in later accounts.

Surprisingly few studies have utilized psychological models to understand and predict the use of CAM. Despite the extensive use of the Theory of Planned Behaviour (TPB) to predict a host of behaviours in health and social psychology, only one published study has applied it to the prediction of CAM use, specifically the self-reported use of homeopathy (Furnham and Lovett, 2001). This prospective study found that attitudes, subjective norms and perceived behavioural control predicted 49% of the variance in intention to use homeopathy, while intention predicted 56% of the variance in behaviour (frequency of homeopathy use).

Another psychological model that has been under-utilized in CAM research is Leventhal’s self-regulation model which posits that people’s perceptions of their illness help them to make sense of their condition and guide their coping responses, such as the decision to use CAM or take medication (Leventhal et al., 1980, 1984). Illness perceptions consist of beliefs about symptoms, aetiology, illness duration, consequences and potential for cure or control (Leventhal et al., 1980; Lau and Hartman, 1983). Also relevant to treatment decisions are beliefs about the treatment itself, such as whether it is harmful or necessary (Horne, 1997, 1999). Although this model suggests a useful framework for understanding CAM use within the wider context of the illness experience, its application to CAM use has been limited. A small longitudinal study (N = 30) with users of homeopathy found causal beliefs to be most predictive of understanding and adherence to homeopathy (Searle and Murphy, 2000). A larger cross-sectional online survey found that illness (beliefs in serious consequences, emotional causation and illness coherence) and treatment beliefs (holistic health beliefs) were predictive of current CAM use (Bishop et al., 2006). Additionally, different beliefs were associated with the use of different CAM therapies. The sample was however, biased towards those with favourable attitudes towards CAM, with the majority having used at least one therapy in the past. Further work is warranted in this area, not simply to predict CAM use but
to better understand the role of CAM in how people interpret and respond to the changing trajectory of illness.

Locus of control (Rotter, 1966) has been extensively studied within psychology and linked to a variety of health-related beliefs and behaviours (Norman and Bennett, 1996). It assumes that people have generalized expectancies regarding their control over their environment. Individuals with high internal control interpret events as resulting from their own behaviour, while those with external control attribute events to factors outside their control such as luck, chance, fate and the impact of powerful others. While having control over one’s health and treatment is a significant factor in people’s decisions to use CAM (Kelner and Wellman, 1997), findings regarding the more general concept of locus of control are rather mixed. Several studies using Lau’s (1982) health locus of control scale found that users of CAM reported higher self-control over health (Furnham and Bhagrath, 1993) and lower provider control over health (Furnham and Smith, 1988; Furnham and Kirkcaldy, 1996). However, this latter finding may simply reflect a scepticism of conventional medicine, since the provider control sub-scale referred specifically to ‘doctors’ rather than health professionals more generally. A more recent study using the multi-dimensional health locus of control scale found no differences in control beliefs between non-users, new users and committed users of CAM (Sirois and Gick, 2002).

Although we have discussed in some depth the beliefs of CAM users, it should be reiterated that the strength and prevalence of such beliefs are likely to vary according to the modality preferences of individuals. Some therapies have greater legitimacy, regulation and integration with conventional practices (e.g. osteopathy, acupuncture), while others remain on the ‘fringes’ (e.g. Reiki). The beliefs and motivations underlying such choices are therefore likely to vary considerably. A related issue is the impact of different institutional contexts on beliefs and expectancies. The majority of research has been conducted with users of privately funded CAM, but as CAM becomes increasingly available of the NHS, there is a need to explore pathways to publicly funded CAM and its relationship with experiences of care. Several previous qualitative studies with both homeopathy (Barry, 2002) and acupuncture (Paterson, 2004), have suggested that there may be differences in outcome according to the way in which the therapy is practised, namely the utilization of a traditional vs. medical approach. The relationships between beliefs, treatment context and outcomes have not, however, been explored systematically. The impact of cultural factors on decisions to use CAM is also an under-researched area, with the majority of studies being conducted with predominantly white, middle-class participants. Considering the importance of cultural factors to the development of health and illness beliefs, it is somewhat surprising that there is such a paucity of research into ethnic differences in attitudes and use of complementary therapies.
Attitudes within conventional medicine

In conjunction with the increasing popularity of CAM among patients, a growing number of studies have explored the attitudes and behaviours of health professionals towards CAM with several reviews of the literature in the UK (Botting and Cook, 2000) and internationally (Ernst et al., 1995; Astin et al., 1998; Hirschkorn and Bourgeault, 2005). Broadly speaking, these studies indicate an interest and acceptance of CAM within conventional medicine but also concerns about the evidence base for complementary therapies. One of the first UK studies was conducted over two decades ago with a small sample of GP trainees attending a training conference (Reilly, 1983). It found that over 80% viewed acupuncture as useful, and 50% considered homeopathy and osteopathy useful. Additionally, 20% reported using CAM therapies and a third had made referrals. Although this was a small unrepresentative study (N = 86), it revealed a positive attitude towards CAM that is mirrored in larger more recent studies in the UK and elsewhere. One such study (van Wersch et al., 2003) found a positive attitude towards CAM in 87% of the 84 practising GPs in the Northeast of England. However, 37% of these took the opportunity to vent their concerns in the open-ended final question, by indicating the lack of evidence of these therapies, and the uncertainty of these practitioners’ qualifications. Several referred to the possibilities of ‘dubious practitioners’, ‘quacks’ and ‘mumbo jumbo’.

Various methodological limitations have hampered drawing conclusions in this area, in which most studies remain small scale, unrepresentative and lacking questionnaire standardization or validation. Moreover, definitional variations of what constitutes CAM once again raise difficulties of equivalence and hamper cross-cultural comparisons. Despite such methodological variability between studies, Ernst et al. (1995) conducted a meta-analysis with 12 studies using an expert grading system to evaluate perceived physician effectiveness of CAM. They conclude that doctors perceived CAM as ‘moderately effective’, which they contrast with the actual evidence of efficacy from randomised controlled trials. In a later review of 25 international studies, Astin et al. (1998) argued that a meta-analysis was inappropriate given the variability in the methodology of the studies. They found that half of physicians believed in the efficacy of at least one CAM modality, with 43% referring for acupuncture, 40% for chiropractic and 21% for massage. Both studies found that manipulative therapies (e.g. osteopathy and chiropractice) followed by acupuncture are commonly viewed as among the most effective therapies. Indeed, these therapeutic systems are the most easily incorporated into the biomedical framework.

The majority of surveys have been carried out with general practitioners or medical students. It might be surmised that GPs are more holistic in their approach to medicine and therefore more open to CAM. Indeed, Thomas, Fall, & Nicholl (2001) estimate that 40% of GPs are involved in the
provision of CAM in the UK. In a comparative study, Perkin et al. (1994) investigated the attitudes of hospital doctors (N = 81), GPs (N = 87) and medical students (N = 237). The latter were the most enthusiastic about CAM but the least informed. This supports a number of findings that student and younger doctors are more favourable towards CAM (White et al., 1997; Botting and Cook, 2000; Easthope et al., 2000). Twenty per cent of GPs and 12% of consultants were practising CAM, with the majority of both groups (93 and 70% respectively) having made at least one referral to an external CAM practitioner. In a national study focusing on the attitudes of hospital physicians towards CAM, Lewith et al. (2001) sent questionnaires to all members of the Royal College of Physicians in the UK. Although the response rate was low (23%), the sample included 2748 physicians from a range of specialities. They found that 41% of doctors referred patients to CAM, although referral rates were low with the majority referring 0–1 patients per month. Using a conservative estimate by assuming that all non-responders had no involvement with CAM, they suggest that at least 1 in 10 specialists are using or referring to complementary therapies in the UK. Rather worryingly, only 13% of those using CAM had any specific training, which echoes previous findings (Botting and Cook, 2000). This raises serious issues regarding both safety and appropriateness of CAM use by physicians.

Despite the lack of large representative national studies on health professionals use of CAM, the available evidence suggests that patient demand influences health–provider behaviour (Astin et al., 1998) and that attitude, together with training, is the strongest predictor of use of CAM (Hirschkorn and Bourgeault, 2005). In a critical review, Hirschkorn and Bourgeault (2005) argue that the literature is primarily descriptive and lacks ‘adequate theorization of constructs’ in explaining provider attitudes and behaviour. Despite apparently positive attitudes, evidence suggests that this is not necessarily put into practice, thus ‘a substantial degree of slippage exists between attitudes and behaviour, whereby an expressed positive or negative attitude does not easily equate with positively or negatively orientated professional behaviour towards CAM’ (Hirschkorn and Bourgeault, 2005, p. 157). For example, while younger doctors report more favourable attitudes towards CAM, they are less likely to refer patients (Lewish et al., 2001). Of course the attitude–behaviour gap is a well-observed phenomenon in health psychology and has received considerable attention by theorists using a social cognition framework. It is therefore rather surprising that no studies have been conducted using psychological models to predict physician behaviour.

Using a sociological framework, Hirschkorn and Bourgeault (2005) propose a comparative conceptual model (see Figure 1.1) that attempts to contextualize health providers’ decisions and highlight areas that might account for conflicting findings in the literature. Provider factors include personal characteristics such as age and sex, and professional characteristics such as consultation style and CAM training. They point out that despite discrepancies between personal and professional viewpoints, they are not
always fully differentiated in the literature. In terms of patient characteristics, research indicates that practitioners are more likely to use/refer patients to CAM for certain conditions or illness states such as palliation (Lewith et al., 2001), but beyond this we know little about how the practitioners’ attitude towards patients impacts on their behaviour. Modality factors particularly relate to the degree of epistemological ‘fit’ between specific complementary therapies and biomedicine. This may explain why some therapeutic systems are more acceptable to orthodox practitioners, since their mechanisms can be interpreted within a biomedical explanatory framework (e.g. acupuncture and chiropractic). Since this in turn influences status and referral rates, it again highlights the professional hegemony of biomedicine. Structural factors are primarily framed in terms of barriers to CAM use, such as lack of time, potential for liability, and financial constraints, although exactly how practitioners negotiate such factors is under-researched. Finally, Hirschkorn and Bourgeault highlight the under-development of research into contextual factors which incorporate socio-cultural and political-economic influences and impact upon how CAM is viewed within a society. Indeed, such criticisms are levelled more generally at health psychology and its neglect of wider socio-cultural and political influences on health (Marks, 1996; Murray and Campbell, 2003).

Figure 1.1 A conceptual framework of health care providers’ attitudes/behaviours regarding CAM

Source: Hirschkorn and Bourgeault (2005).
Despite a lack of theorization in this area, surveys consistently highlight several issues which act as barriers to a more extensive integration of CAM: lack of information about the effectiveness of therapies, lack of health professional knowledge about CAM, lack of statutory regulation, and concerns about the possible harmful effects of treatment (BMA, 1993; Botting and Cook, 2000). It has been suggested that the spread of CAM within conventional medicine reflects public need/demand rather than evidence-based practice (Botting and Cook, 2000). Personal endorsement by patients appears to be a key factor in predicting positive attitudes of health professionals (Easthope et al., 2000). Certainly, the use of CAM by orthodox practitioners without sufficient knowledge or training highlights the importance of adequate regulation within conventional medicine (Botting and Cook, 2000; Lewith et al., 2001; Owen et al., 2001). It is therefore of no surprise that CAM practitioners have concerns that their expertise and the effectiveness of their therapies may be under-valued by the practice of orthodox practitioners.

In summary, while studies suggest that health care professionals hold favourable attitudes towards CAM with considerable numbers either practising or referring patients, methodological and theoretical shortfalls limit the generalizability of the findings. Additionally, discrepancies appear to exist between doctors’ attitudes towards CAM and (a) their actual behaviour and (b) patients’ perceptions of doctors’ attitudes. A number of studies have pointed to the fact that the majority of CAM users do not disclose this to their doctors (Sharma, 2001; Robinson and McGrail, 2004). The primary reason given is the perception that their doctors are not supportive of their CAM use (Williamson et al., 2003; Robinson and McGrail, 2004). Further theory-based research is necessary to disentangle the complexities of health care providers’ attitudes towards and use of CAM in their clinical practice.

Well-being: a new direction for health care?

It has been suggested that conceptions of health have moved beyond the narrow definitions espoused by biomedicine to a much broader view of health as a ‘state of well-being’ which entails the individual assuming greater responsibility for their health (Coward, 1989). This search for well-being may be a key factor in explaining the popularity of CAM, since its holistic approach is perceived as better able to address the needs of the ‘whole’ individual. Certainly, as we have seen, users of CAM are more health conscious, more concerned with the prevention of ill-health and more likely to adopt healthy behaviours (Furnham and Kirkcaldy, 1996; Kelner and Wellman, 1997).

However, well-being remains a nebulous concept that may include health but also goes beyond it to include vitality, happiness, creativity and fulfillment (Huppert et al., 2005). From a psychological perspective, well-being is
generally equated with life satisfaction and happiness (Kahneman et al., 1999), factors that are associated with better health but are not typically incorporated within the treatment goals of health care. Despite the broad nature of well-being, there is frequently little differentiation between health and well-being in the literature. In contrast, a phenomenological study specifically explored the meaning of well-being for lay people, using a range of methods including multiple interviews with participants (Schickler, 2005). Schickler (2005) identified three key themes: energy and vitality, ‘to enable one to do all that one wanted to do’; being in control of one’s life, including decision making and independence; and ethical congruity, living in accordance with one’s values and beliefs. Such themes resonate with qualitative studies that have identified ‘expanded effects’ of CAM which relate to wider psycho-social improvements in people’s lives beyond specific health problems (Cassidy, 1998; Paterson and Britten, 2003; Cartwright, 2007). In Schickler’s study, consulting a conventional or complementary practitioner was seen as one means of either restoring or maintaining well-being, although lifestyle factors such as diet and stress reduction were most commonly reported. Additionally, health practitioners were rated as a source of loss of well-being when experiences were negative.

This has several implications for health care practice. First, CAM is inherently more orientated towards the broader concept of well-being (as opposed to health) with greater time and focus on the consultation process, individualized treatments and greater attention to the active participation of the patient through lifestyle change. Traditionally, many complementary therapies such as acupuncture have focused on the maintenance of health and energy rather than the treatment of illness. Additionally, the goal of treatment for many people using CAM, particularly long-term users, is to enhance well-being rather than to simply address illness (Gould and MacPherson, 2001; Paterson, 2004; Verhoef et al., 2005). However, looking at well-being in its wider context, to what extent does it reflect middle-class beliefs and access to resources? Research considered earlier (e.g. Chamberlain, 1997) suggested significant class differences in perceptions of health, with a middle-class focus on vitality and well-being compared with the utilitarian focus of lower SES groups. Since the majority of complementary therapies are purchased privately at considerable cost, the prevalence of CAM use in higher SES groups reflects wider inequalities, in which individuals from lower SES groups have poorer health but are less likely to use health care (Carroll, et al., 1993; Wilkinson, 1996; Marmot, 2001).

To what extent has conventional medicine taken on board the concept of well-being? While its focus remains on the biomedical, it has arguably responded to the shift in attitudes by moving towards a more participatory patient role (Coulter, 1999; Say and Thomson, 2003; Haywood, et al. 2006), in discourse if not always in practice. Similarly, the increasing ‘problem’ of chronic illness requires greater attention to quality of life issues and acknowledgment of the central role the patient plays in managing their own
condition, hence the attention given to the expert patient programme. According to Kelner and Wellman (2001) ‘well-being is a state which can only be achieved if the individual is prepared to work at it through exercise, diet and other kinds of self-discipline’, suggesting that an active role in one’s health care in crucial to this state. However, despite all the rhetoric around patient-centred care and active engagement of the patient, not everyone desires a more participatory role in health care decisions. Indeed, many patients fear making the wrong decision and prefer the more traditional directive approach (Savage and Armstrong, 1990; Lupton, 1997). As we have seen, complementary medicine particularly appeals to those who want to have more control over their health and treatment decisions. Both conventional and complementary medicine have the potential to facilitate well-being through the control of symptoms and empowerment of patients. However, the particular focus of CAM on a holistic, individualized approach to diagnosis and treatment and the precedence on the therapeutic relationship suggest an approach that is particularly congruent with the wider concept of well-being.

**Summary and implications**

With the current policy emphasis on patients as “partners” in health care, able and expected to make informed decisions about the treatment they receive, it is no longer tenable to ignore this clearly stated demand for CAM health care.

(Thomas, Nicholl and Coleman 2001, p. 10)

This chapter has explored the context in which health care decisions are made and looked at the reasons why increasing numbers of people are choosing to use CAM, often at considerable financial cost. Research presents a picture of CAM users as critical ‘smart consumers’ for whom decisions about using CAM are based on personal models of health and illness, experiences of medical care, health need and access to services. Although often dissatisfied with conventional medicine, the majority of people are not rejecting this approach to treating illness, but rather supplementing it with alternative practices. This therefore reflects wider cultural changes in which people are more informed about health matters and willing to meet their health needs by adopting more pluralistic health practices.

While 90% of CAM remains in the private sector (Thomas, Nicholl and Coleman, 2001), there is increasing pressure from patients for CAM to be made more widely available on the NHS. Research with health professionals, mainly doctors, demonstrates generally positive attitudes towards complementary therapies, particularly those that are more congruent with a biomedical framework, such as manipulative therapies and acupuncture. However, such attitudes are not always translated into referral behaviours.
and, more worryingly, there is evidence that a minority of health professionals are using CAM without sufficient training (Botting and Cook, 2000; Lewith et al., 2001). For health professionals, any further integration of CAM into mainstream health care requires evidence-based research, adopting a biomedical methodological framework. The tensions and applicability of such methods to CAM are discussed elsewhere (see Chapters 2 and 4). For patients however, personal legitimacy based on factors personally relevant to the individual such as treatment effectiveness, is likely to take greater precedence than scientific evidence in treatment decisions:

for many patients the question of scientific proof is equally irrelevant. They have already tried orthodox remedies which are supposed to have been subjected to rigorous testing but which have not worked for them.

(Sharma, 1992, p. 206)

Research in this multi-disciplinary area has been somewhat piecemeal, and frequently descriptive rather than analytical or theoretical in focus. Additionally, the huge range of complementary therapies subsumed under the umbrella of CAM make generalizations about ‘CAM users’ problematic. Therapies vary in their epistemology, application, degree of regulation, evidence base and acceptability within the biomedical paradigm, all of which are likely to impact on their appeal to both consumers and health professionals. The majority of research also provides a ‘snapshot’ of CAM users at a single point in time and does not distinguish between different types of user (e.g. committed vs occasional user). Consequently it is difficult to determine if people’s beliefs about health and illness underlie motivations for using CAM or whether such beliefs are a product of the treatment itself. In order to unravel the complexities in this area, there is a need for prospective and longitudinal research together with theory-based and inquiry-focused methodological approaches.

Note

1. Findings regarding control beliefs are inconclusive – this is discussed further later in this section.