

Chapter 2

Psychotherapy in Cancer

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Abstract The present chapter reviews the current and popular therapies used to alleviate psychological trauma of cancer resulting in adverse and disturbing behavioural and psychological reactions. These therapies, including alternative medicine, may also be used to promote psychological well-being in cancer patients. We discuss the most common cancers and mention major charity and NGO organizations in the Middle East and Europe. We also discuss why cancer patients seek such therapies and some of the challenges and obstacles facing successful therapy for cancer.

Keywords Type of cancer • Choice of therapy • Therapy for cancer patients • Alternative medicine • Cancer • Psychotherapy

2.1 Introduction

It is said that most people will die with cancer, though not necessarily from it. Cancer medicine and research has progressed considerably over the past twenty years at least in the developed world. Both the detection and the cure of cancer have advanced considerably. It appears to be the case that the incidence of cancer is growing though it is not clear whether this is true or else detection is becoming more efficient and/or people are living longer.

There are various common types of cancer all of which can influence the type of medical and psychological cure that is sought. Some cancers are more observable (i.e. melanoma) than others; some lead to immediate and potentially embarrassing

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issues around daily life (i.e. bladder and colon cancer), while other may require surgery which affects cosmetic issues that can profoundly influence social self-confidence and sexual behaviour (i.e. breast, prostate).

Most common types of cancer (according to American Cancer Society: Cancer Facts and Figures 2015. Atlanta, Ga: American Cancer Society, 2015).

Type of cancer	Estimated new cases
Bladder	74,000
Breast (female-male)	231,840–2350
Colon and rectal (combined)	132,700
Endometrial	54,870
Kidney (renal cell and renal pelvis)	61,560
Leukemia (all types)	54,270
Lung (including bronchus)	221,200
Melanoma	73,870
Non-hodgkin lymphoma	71,859
Pancreatic	48,960
Prostate	220,800
Thyroid	62,450

In most countries there are large cancer charities. Some support research, others patients and still others relatives. Some specialise on particular illnesses. For instance in Great Britain Macmillan Cancer Support is one of the largest British charities and provides specialist health care, information and financial support to people affected by cancer.

The charity was founded, as the *Society for the Prevention and Relief of Cancer*, in 1911 by Douglas Macmillan following the death of his father from the disease. In 1924 the name was changed to the *National Society for Cancer Relief*, which it retained until 1989 when it was changed to *Cancer Relief Macmillan Fund*, later changed again to *Macmillan Cancer Relief*. From 5 April 2006 Macmillan Cancer Relief became known as *Macmillan Cancer Support* as this more accurately reflects its role in supporting people living with cancer. It has adopted the principles of being a “source of support” and a “force for change”. This chapter is about the choice and use of psychotherapy in cancer patients. For most patients the initial diagnosis of cancer is acutely traumatic. It triggers off a range of emotions in themselves and those to whom they disclose the information including acute depression and suicidal thoughts. This in turn leads immediately to thoughts of cure and anxiety alleviation. The choice of therapy is for many considerable. The internet is full of ideas to both prevent and cure cancer.

It is interesting to note that such cancer charities are growing very fast in developing countries too. This is of great importance since cancer care is more difficult in developing countries. Drugs are inevitably more scarce and expensive and access to treatment, particularly psychological and social care by people living in more remote areas is more difficult.

Two charity organizations in Iran, for example have gained international status and are worth mentioning here. The Society to Support Children Suffering from Cancer widely known by its acronym, MAHAK, was set up in 1991 as a non-governmental and non-profit organization with the Department of Social Affairs for NGO activities at the Ministry of Interior of the Islamic Republic of Iran. Behnam Daheshpour Charity (BDC) is a non-governmental and non-profitable organization run by public donations and has one of the largest group of unpaid volunteers to care for cancer patients across Iran. The main duty of this organization is to support and help cancer patients. This charity was established in 1997 and named after the founder Behnam Daheshpour who himself suffered from cancer and passed away in the age of 21. BDC has looked after over 7000 cancer patients covered since 1997.

MAHAK strongly supports the parents of the children suffering from cancer. With such support, parents can concentrate on the treatment of their children. The motto of the charity is that no child with cancer will ever be refused treatment because of poor financial status.

Both charities provide supportive psycho-social and welfare services to deprived children and their families. Support services include social work, psychology and welfare services in addition to collection of donations and humanitarian assistance from people, institutions and organizations. Fundraising activities include donation boxes, membership schemes, advertising and special projects including art exhibitions as well as Public and International Relations that keep rapport with volunteers, donors at national and international level (Fig. 2.1).

The highly specialized paediatric hospitals working and liaising with these charities offer the latest methods and technology in detecting and treating cancer such as Leukemia, Brain tumors, Bone tumors, etc. (Fig. 2.2).

There are essentially two issues for most patients.

The first is how to cure the cancer in the sense of preventing its growth and eradicating it. For most this will involve some form of medical treatment such as chemo-therapy or surgery or radio-therapy but could also involve many other treatments.



Fig. 2.1 Behnam Charity Organization in Iran



Fig. 2.2 Cancer care has grown significantly in the Middle East through charity organizations and NGO's

The second is dealing with the anxiety and life-style changes that result from the diagnosis. This may involve a wide range of orthodox and novel “talking cures” or psychotherapies, as well as dietary and exercise changes as well as spiritual exercises.

Below are the sites that first come up when Googling (In 2015) what to do after one has received a cancer diagnosis:

1. Cancer Support Community (http://www.cancersupportcommunity.org/MainMenu/About-Cancer/Newly-Diagnosed/Emotional-Distress.html?gclid=CjwKEAajw2cOsBRD3xNbRp5eQxzYSJADZGYbz1HkNcy4_cnQfn_AwwK8XmZPJJoUPI7n7hsBwhIhsPNRoC3kzw_wcB): newly diagnosed individuals can follow 10 links that include information regarding: Coping with Diagnosis, Coping with the Cost of Care, Communicating with your Healthcare Team, Treatment, Open to options, Managing Emotions, Emotional Wellbeing, Support, Keys to Being Patient Empowered and Relaxation and Visualisation.
2. Mayo Clinic (<http://www.mayoclinic.org/diseases-conditions/cancer/in-depth/cancer-diagnosis/art-20046527>): cancer specialist's advice on what to do after the diagnosis including finding out the details of the diagnosis and having someone with you who will help in retaining this information. Moreover, second opinion is recommended as well as what to look for in a doctor (listening, explaining, understanding). The specialist also advises that one should consider all types of treatment and choose the one more appropriate for their case. Finally, he suggests that one should value their personal opinion on treatments more than those of their family and friends as they can be overwhelming.

3. WebMD (<http://www.webmd.com/cancer/features/cancer-diagnosis-what-to-do-next>): STEPS: Find a partner, Get organized, Get informed, Be sure to consult only unbiased, trustworthy sources when you do your research, Consider a second opinion, Understand treatment options, Communicate with Friends and Family Members, Financial Self-Care.
4. Cancer.net (<http://www.cancer.net/navigating-cancer-care/diagnosing-cancer/when-doctor-says-cancer>): Learn about your diagnosis, Find medical care, Get organized, Find support to cope with challenges, Emotional support, Financial support.

In this chapter we will concentrate on three things. The first is the choice of therapy offered to patients. The second is the evidence of the efficacy of the therapy in general, but also specifically for cancer patients. The third is the use of alternative medicine in the treatment of cancer.

2.2 Choice of Therapy

The general public (as potential clients) is increasingly faced with a bewildering array of psychotherapy interventions available, although some are clearly similar in theory and practice. These include seeing a therapist, and/or taking medication or getting hypnosis. Deciding whether or not to seek help is associated with a range of factors including the availability of services, financial costs and individual socio-demographic and psychological variables. It is also crucially associated with the perceived effort required in, and possible psychological pain associated with, treatment which is the focus of this paper. The term psychological pain refers here to the distress associated with the treatment process.

Generally most members of the public believe that mental disorders, like the anxiety and depression that results from a diagnosis of cancer are treatable, psychiatric treatments are considered generally rather unhelpful whereas counselling is considered most helpful. Studies have also shown that people have set ideas about counselling before taking up therapy. Expectations have been found to be important determinants of where people turn to for help and effectiveness of counselling.

People have very different beliefs about what occurs during psychotherapy (Furnham and Telford 2012). Furnham and Wardley (1990) found respondents tended to believe that clients of psychotherapy did feel better in therapy, and were more confident and hopeful. Furnham and Wardley (1991) investigated lay theories of efficacy of therapies and prognosis for different problems. The more knowledgeable people were about psychology, the more sceptical they tended to be. Knowledge about psychological cures led to a greater awareness of the limited benefits of therapy. This was confirmed when Furnham et al. (1992) compared responses of lay adults, students and clinical psychologists and found the latter tended to be more cynical about the efficacy of therapy and prognosis of many disorders.

Lay theories about the *treatment*, as opposed to the cause, of mental disorders show marked differences from current practices in the mental health service. It has been found that lay people generally prefer psychotherapy to drug treatment, due to the perceived side effects. There is also a belief that 'will power' can effectively facilitate recovery from mental disorders such as agoraphobia and anorexia nervosa. However, medication is believed to be the most effective treatment for disorders with a higher perceived severity thus showing that lay and academic theories of treatment overlap to an extent.

However it is common for cancer patients both to be offered and to seek out some form of psychological treatment to help them adjust to their medical condition:

1. Chemotherapy—prescribing specific drugs to achieve a therapeutic purpose
2. Electroconvulsive therapy—electric shock treatment to cause convulsion
3. Psychosurgery—destruction of specific brain tissue to control behaviour and emotions
4. Megavitamin therapy—administering large dosages of specific vitamins
5. Psychotherapy—a talking cure aimed at changing feelings, attitudes and behaviour
6. Psychodynamic therapy—often based on Freudian ideas and stressing unconscious processes and early relationships
7. Systematic desensitization—people are helped to relax in situations that cause them great anxiety
8. Implosion therapy—exposing people to situations and things that cause them most fear
9. Aversion therapy—pairing an unpleasant event (shock) with an undesirable habit (drinking)
10. Token economies—rewarding and fining people for desirable and undesirable behaviour
11. Behaviour contracting—establishing a written contract/promise of appropriate behaviour pattern
12. Modelling/role playing—watching and then imitating a therapist showing an appropriate behaviour pattern
13. Assertiveness training—helping clients to express in various social contexts more effectively their needs and emotions
14. Rational-emotive therapy—helping people to think more rationally and be less magic-orientated or superstitious
15. Thought stopping therapy—helping people stop obsessive or compulsive thoughts
16. Non-directive therapy—therapist encourages talking but does not give advice, reassure or ask direct questions but does clarify, reflect and emphasise the positive
17. Existential therapy—helping people to be more aware and responsible for the choices in all areas of life experience

18. Gestalt therapy—helping people who intellectualize their problems by forcing them to confront conflicts and express emotion
19. Hypnosis—getting people into an altered state of consciousness and suggesting behavioural or attitudinal changes and helping them recall experiences
20. Biofeedback—helping people to relax and reduce anxiety by monitoring their physiological responses (heart rate)
21. Group therapy—getting groups of fellow sufferers to provide support and feedback
22. Primary scream (rebirth) therapy—attempting to get people to relive the trauma of their birth.

Many would object to this list because it is not inclusive and tends to group different therapies together. Thus there is Adlerian, Freudian, Jungian, Kleinian and various other psychotherapies that may be grouped under the Psychodynamic tradition. Others would talk about general counselling done by specialists.

Inevitably there has grown up specialist therapies for those who have cancer. According to the American Cancer Society some of the most common medical/biological and physiological cancer treatments include

- Surgery
- Chemotherapy
- Radiation therapy
- Targeted therapy
- Immunotherapy
- Hyperthermia
- Stem cell transplant (peripheral blood, bone marrow and cord blood transplants)
- Photodynamic therapy
- Lasers in cancer treatment
- Blood product donation and transfusion.

In their *Handbook of Psychotherapy in Cancer Care* Watson and Kissane (2011) reviewed a whole range of therapies which are summarised below

Type	Definition	Evidence
Supportive psychotherapy	A therapeutic intervention utilised intermittently or continuously that seeks to help patients deal with distressing emotions, reinforce pre-existing strengths and promote adaptive coping with illness. It explores the patient's self, body image and role changes within a relationship of mutual respect and trust	In 2007 the IOM (Institute of Medicine), National Academies of Science and the Committee concluded that a sound evidence base exists to recommend supportive psychotherapy as a valid therapeutic intervention

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Type	Definition	Evidence
Cognitive-behavioural therapies (CT and CBT)	The aim is to understand how a person's cognitive distortions, and subsequent irrational thinking, adversely affect their ability to cope optimally with stressful life events and then to help them to both identify their own distorted beliefs and negative automatic thoughts (NATs), and to challenge these in the light of evidence from actual behaviours of both themselves and others	Greer et al. showed that CBT adapted as an individualised therapy for cancer patients (adjuvant psychological therapy) could significantly reduce anxiety and helplessness compared to a no treatment control group. An advantage of CBT, demonstrated clearly by a number of studies, is its utility to bring positive benefits over a relatively short number of sessions
Cognitive analytic therapy	CAT is a recently developed integrative model of psychotherapy with a major focus on relational aspects of development and psychological distress. It is especially helpful with psychologically distressed, complex or "hard to help" patients. CAT can also be a consultancy tool to assist stressed staff teams and services as well as patients	CAT conforms to recognised general criteria for effective therapies and, in particular, for those more "sever and complex" and "difficult" personality type disorders. An increasing "formal" base, both naturalistic and controlled, has been accruing over recent years, despite its relative youth as a model
Mindfulness interventions	Due in part to the growing impact of Buddhist thought in our increasingly small global village, the concepts of Buddhism in general and mindfulness specifically have entered into the Western vernacular and experience. From this cultural introduction have flowed a variety of approaches designed to enhance quality of life	The review of literature documenting the impact of MBSR on cancer patients looks at psychological and physical symptoms. Significant support exists for the role of MBSR in the amelioration of psychological distress or mood disturbance with lower scores on measures of depression, anxiety, stress, fatigue and fear of recurrence of cancer
Relaxation and image based therapy	Consists of learning different ways in which to reduce the body's stress response in order to induce the "relaxation response". This is characterised by feelings of both physical and psychological relaxation	Relaxation and imagery are amongst the most popular complementary therapies used by patients with cancer. Luebbert et al. conducted a meta-analysis of randomised controlled trials employing relaxation based interventions and found considerable efficacy for the technique

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Type	Definition	Evidence
Motivational counselling in substance dependence	Receiving a cancer diagnosis has been framed as a “teachable moment” when individuals may be particularly receptive to changing their lifestyle or health	Meta-analyses showed a robust effect of this intervention particularly in alcohol-related problems. Effect sizes vary depending upon the comparison group and substance use to outcome, but when compared to wait list or no-treatment group, MI’s average effect sizes were in the small to medium range. Compared to active treatment groups, for example CBT it is equally effective or more so
Narrative therapy	Denotes a number of psychosocial forms of intervention with individuals, couples, families, groups and organisations with a basis in narrative theories. The focus is on the narratives and the outlook and the vocabulary of the client which they bring to the therapy sessions	As of yet there are only a limited number of studies of the effect of narrative therapy
Dignity therapy	A patient-affirming psychotherapeutic intervention designed to address existential and psychosocial distress in people who have only a short time left to live	In a clinical trial of 100 end-stage patients, measures of suffering and depression showed significant improvement. Measures of dignity, hopelessness, desire for death, anxiety, will to live and suicide all showed favourable changes and patients who reported higher initial levels of despair were more likely to benefit
Written emotional disclosure	Based on the common assumption in theories of adjustment to traumatic events, that healthy adjustment occurs through repeated confrontation with the thoughts and memories of the trauma, which will assist the individual interpret the event, in this case the cancer, in a meaningful coherent framework	There is considerable evidence to suggest that a general tendency to cope through emotional non-expression will reduce the chance of adjustment to traumatic events such as cancer

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Type	Definition	Evidence
Supportive-expressive group psychotherapy	It is an intensive, weekly group psychotherapy that addresses fundamental existential, emotional, and interpersonal problems facing cancer patients	There is clear evidence that SEGT has psychosocial benefits. It reduces mood disturbance, depression, traumatic stress symptoms, emotional control, and maladaptive coping, and improves quality of life.
A short term, structured, psychoeducational intervention for newly diagnosed cancer patients	The goals of these interventions ought to focus on decreasing feelings of alienation and isolation by talking with others in a similar situation, reducing anxiety and helplessness about treatments and assisting in clarifying misperceptions and misinformation. The added benefit of such interventions is that they encourage more responsibility to get well and compliance with medical regimens	Following the six-week structured intervention, the experimental subjects showed significantly greater use of active-behavioural coping methods than the control subjects. In addition, the experimental subjects used significantly more active-positive and distraction coping strategies
Meaning-centered group psychotherapy	The goal of the intervention is to diminish despair, demoralisation, hopelessness and desire for hastened death by sustaining or enhancing a sense of meaning, even in the face of death	Early research demonstrated that a one-year supportive-expressive group psychotherapy, which included a focus on existential issues, decreased psychological distress and improved quality of life. However, results are inconsistent in their effects on depression, anxiety and desire for death. Results demonstrated significantly greater benefits from MCGP compared to SGP (supportive group psychotherapy) particularly in enhancing spiritual well-being and a sense of meaning
Couple-focused group intervention for women with early breast cancer and their partners	In order to deal with the many challenges and stresses of breast cancer, couples are likely to depend on one another as a key resource for both emotional and practical support	Couples report enjoying the groups and benefiting from the communication and stress management skills they learn

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Type	Definition	Evidence
Couples therapy in advanced cancer: using intimacy and meaning to reduce existential distress	Strives to optimise communication about several concerns, while helping the couple identify, affirm and “keep in circulation” sources of relational meaning that counter the distress which these dilemmas bring	Evidence supports the utility of couple-based interventions in the setting of advanced illness by improving relationship quality and reducing perceived relationship skew
Therapies of sexual dysfunction	All types of cancer can impact sexuality and intimacy. All patients regardless of age, sexual orientation, marital status or life circumstances should have the opportunity to discuss sexual matters with their health care professional	Evidence shows that a stronger bond is created between the health care provider and the patient and his/her partner after sexuality issues are addressed. If the intervention is ineffective, they are grateful that someone tried to help them
Focused family therapy in palliative care and bereavement	A focus on family-centred care seems imperative once it becomes clear that cure or disease containment is no longer achievable	Modest initial evidence exists

Clearly there is a great need for psycho-therapy of one sort or another to help cancer patients (Breitbart and Poppito 2014). A number of (as yet unanswered) questions arise from this literature. The first is why certain patients chose one therapy over another. The second, perhaps even more important, is the proven efficacy of that therapy.

2.3 Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) has gained wide recognition and CAM is now big business (Ernst and Furnham 2000). Since the turn of the century there has been considerable and sour debate as to the efficacy of alternative medicine. Complementary medicine has been a wildly controversial topic over recent years, as techniques have been rigorously tested and fraudsters revealed. Singh and Ernst (2008) in the book *Trick or Treatment* evaluated 40 complementary techniques, and were scathing in their findings. They found that scientific evidence for the efficacy of these methods was lacking, and that the methods were not just ineffective, but positively dangerous in some cases. For example, methods such as homeopathy are labelled merely as placebos lacking in credible, repeatable effects. Singh was later sued by the British Chiropractic Association for libel for comments associated to the book, although they later dropped the case. Other widely available

books such as *Suckers: How Alternative Medicine Makes Fools of Us All* by Shapiro (2008) follow a similar line.

The great range of CAM inevitably means there is a considerable diversity of therapies and their attendant theories and philosophies. Yet there are common themes in 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: Conventional medical professionals see disease as a specific, locally defined deviation in organ or tissue structure. CAM practitioners stress body-wide signs, such as body language indicating disruptive forces and/or restorative processes.

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 therapists seem particularly hostile to chemical therapies and surgery.

The 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 than 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 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.

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

- (1) *The biomedical perspective:* This is concerned with curing of disease and control of symptoms where the physician-scientist is a technician applying high level skills to his patient. This perspective asserts: (i) that the natural order is autonomous from human consciousness, culture, morality, psychology and the supernatural; (ii) that truth or reality resides in the accurate explanation of material (as opposed to spiritual, psychological or political) reality; (iii) that the individual is the social unit of primary importance (as opposed to society); and (iv) that a dualistic framework (e.g. 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: (i) believing in the

importance of domains other than ‘the physical’ for understanding health, (ii) viewing diseases as symptomatic of underlying systematic problems, (iii) a reliance on clinical experience to guide practice and (iv) 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 (BPS) model. Many advocates are critical of biomedicine’s harsh and often unsuccessful treatments, and point out the paradox of biomedicine often not being based on ‘solid scientific evidence’.

- (3) *The progressive perspective*: Proponents of this perspective are prepared to support either of the above, depending entirely on the scientific evidence. They are hardened empiricists who believe it is possible to integrate the best of biomedicine and unconventional approaches. Like all other health-care professionals, their approach is not value free—the advocates of this approach welcome the scientific testing of all sorts of unconventional therapies.
- (4) *The post-modern perspective*: This approach enjoys challenging those with absolute faith in science, reason and technology, and deconstructing traditional ideas of progress. Followers are distrustful of, and cynical toward, science, medicine, the legal system and institutionalised religion and even parliamentary democracy. Post-modernists see truth as a socially and politically constructed idea and believe orthodox practitioners to be totalitarian persecutors of unconventional medicine. Proponents of this position argue (i) to have a complementary perspective in any debate is healthy, (ii) that CAM practitioners are also connected to particular economic and theoretical interests, (iii) that a variety of values and criteria for assessing success is beneficial and (iv) that the ill people themselves should be the final arbiters of the success of the therapy.

There is more diversity than unity within CAM. Whilst 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 CAM specialities.

The popular interest in CAM has been matched by a relatively sudden and dramatic increase in research into the two central questions in this area:

1. Does it work?

Is there good evidence from double-blind, placebo-controlled, randomised studies that the therapy “cures illness” as it says it does? That is, is there any indisputable scientific evidence that documented findings of success are due to anything more than a placebo effect? Properly designed and executed studies are complex, 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. The answer to the question is that either very little or no good evidence is available for the efficacy of most CAM, with the possible exception of herablism. However, as more and more sophisticated meta-analyses are published, there does seem to be clear evidence for small but robust positive effects of specific CAM treatments (Ernst and Pittler 1998).

2. *Why choose it?*

If the evidence is limited, equivocal and indeed often points to lack of efficacy, the central question must be why do 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. They concern the often mixed motives that patients have in shopping for health treatments.

The principal reason for individuals beginning any CAM treatment appears to be that they regard it as more natural and effective, and it allows a more active role for them. The second reason is the failure of orthodox medicine to provide relief for specific (usually chronic) complaints. The adverse effects of orthodox medicine, and a more positive patient-practitioner relationship are also important for many patients. There is little to support the widely held view that CAM-seeking patients are especially gullible or naïve, or have unusual (neurotic) personalities or (bizarre) value or belief systems. However, comparisons of users and non-users of CAM have shown evidence of different beliefs about health and disease in general.

2.4 Differences in the Consultation Between CAM and Orthodox Medicine

Are the popularity of CAM and its powerful placebo effect due to the often fundamental and dramatic differences between the stereotypic CAM and orthodox medicine (OM) consultation? There is only a very limited amount of research in this area.

Is it possible to generalise? Is there indeed such a thing as a typical consultation? Is the variation within each group (i.e. CAM vs. OM) different from/greater than the variation between each group? The differences between the consultations of an aromatherapist compared to an osteopath, or a psychiatrist compared with an orthopaedic surgeon consults are considerable. Indeed there may be different “schools of thought” which results in different types/styles of consultations within each CAM or OM speciality. Then, there may be differences depending on the biography, demographics and training of the individual practitioner. A typical consultation may be hard to define.

Consultations are so varied that any generalizations about the difference are only stereotypical, possibly misleading or meaningless.

And yet patients and practitioners acknowledge, even celebrate, the particular and peculiar approach to the consultation. Table 2.1 shows sixteen different criteria on which these two may differ and may in part explain the popularity of CAM. GPs all too often have too little time, may be perceived as patronising, and may not examine (touch) the patient. Further, patients are often not asked the full set of questions they expect to be asked for a “full” diagnosis. In short they are not treated like a modern adult consumer. CAM practitioners have longer consultations, appreciate patient’s need to talk, to be examined/touched etc. The question is how the traditional/average CAM consultation is different from (better than) the

Table 2.1 The prototypic CAM and OM Consultation

	CAM	OM
Time	More	Less
Touch	More	Less
Money	More	Less
History taking	Holistic	Specific
	Affective	Behavioural
Language	Healing	Cure
	Holistic	Dualistic
	Subjective	Objective
	Personal story	Case history
	Wellness	Illness
Patient role	Consumer	Sick role
Decision making	Shared/consumer	Doctor/paternalistic
Bedside manner	Charismatic	Cool
	Empathic	Professional
Sex ratio/role	F = M Feminine	M > F Masculine
Time spent talking	Patient > or = to practitioner	Practitioner > patient
Style	Authoritative	Authoritarian
	Supportive	Information
	Counselling	Advice giving
Confidence in methodology/outcome	Very high	High
Client relationship	Long term	Short term
Consulting rooms	Counselling	Clinical
Practitioner history	Second Profession	First Profession
Ideology	Strong Left wing	Moderate Middle way

traditional orthodox consultation. It is possible to compare and contrast the typical GP and CAM consultation across a number of variables (history taking approach, language used, patient role, decision making process, bedside manner etc.) to show how different they are, which may account for the popularity of the latter. Research is needed to confirm the view that it is very much the nature of the consultation which both differentiates CAM from OM and make it attractive. Current evidence supports this view.

There is some evidence that frequent CAM users are more health conscious and believe more strongly that they can influence their own state of health, both by lifestyle and through maintaining a psychological equilibrium. CAM patients appear to have less faith in 'provider control', that is in the ability of medicine (specifically orthodox doctors) to resolve problems of ill health.⁵ Patients with

cancer using CAM were more likely 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.

- (a) *People shop for health.* They want to use all possible (and affordable) options in health care. People are not loyal to a brand, to orthodox medicine or any particular therapy. They shop, try-out, and experiment. CAM is therefore to many just another product/service. The question is how the particular brand offers something quite different that no other product or service offers. This raises the question as to what makes an individual “brand-loyal”; that is loyal to a therapy, a therapist or indeed a place of treatment.
- (b) *People want a cure without side effects or pain.* This may offer a very strong, unique selling point for homeopathy over herbalism, acupuncture etc. because of the scare stories about poisoning with herbs or minerals, and pain/infection with acupuncture. It is for instance the “gentleness” of homeopathy and its dilutions that may be particularly attractive to people. The possible contradiction between being harmless *and* effective is often not confronted.
- (c) *Because they have chronic illnesses or conditions they have difficulty living with.* Many patients with chronic painful conditions or addictions have tried many other cures. They turn to CAM sometimes as a last hope. Some therapies have a powerful psychological component, particularly those associated with touch (i.e. massage, reflexology).
- (d) *Because they are disappointed by the traditional orthodox consultation.* As shown in Table 2.1, there are many reasons for patient’s disappointment with orthodox medicine, but it seems that the nature and style of the consultation is the primary explanation of this.
- (e) *Because patients want to learn more about self-care (fitness, wellness and prevention).* Orthodox medicine is seen as narrow and disease (complaint) orientated, which aims to destroy, demolish or suppress “sickening forces”, through such things as chemical therapies and surgery. But many people prefer an emphasis on natural restorative processes on how to strengthen the vitalising health-promoting forces. The emphasis is quite different—illness versus wellness. Psychologists have long recognised this. CAM is often seen as restorative, balancing, natural and preventative, which fits in with the particular *zeitgeist*.
- (f) *Patients believe in the “holistic” message.* It seems obvious to most patients that life-style, personal relationships and work operate together and simultaneously to 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 non-verbal signs associated with gait, balance, body odour, etc. The implication is that the diagnostic interview needs to have questions about all aspects of the person’s life not only their physical symptoms.

2.5 Conclusion

The diagnosis of cancer for any individual, as well as his/her family and friends, can be devastating. It can lead after shock and surprise to acute anxiety and depression. This can make the medical situation worse as the patient may make poor health decisions, not follow advice or increase the possibility of psychosomatic disorders.

This, in turn, may lead medical experts to advise a patient to seek psycho-therapy of one sort or another. Some patients may be directed to a particular type of therapy, while others may seek it out of their own accord. The number of people seeking out “cures” on the web has grown exponentially and doctors are increasing wary of patients coming to see them with computer sticks or bulging files of “information and advice” they have gleaned from different websites. It is often a testament to their fear and desperation.

There are many factors determining when, why and what sort of psychotherapy they seek. Firstly choices may be severely limited depending on where the patient lives, as well as his/her resources. Psychotherapy of any sort may be unavailable or only at a cost that the patient may not be able to afford. Secondly, some are very strongly directed to one sort of therapy or another. There may for instance.

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