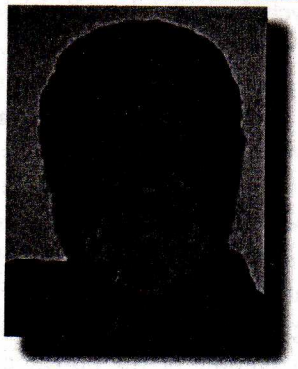

Complementary and Alternative Psychology: A Return to our Roots?

An Opinion by John C. Rhead, Ph.D.

Four years ago I published an editorial in a medical journal suggesting that the most significant aspect of Complementary and Alternative Medicine (CAM) is its ability to attach significance to subjective data (Rhead, 2003). That editorial opened with the following paragraphs:

> The term "complementary and Alternative Medicine," or "CAM," intrigues me. It always seems to imply something new or radical is occurring, and stirs a certain revolutionary excitement in me. It is as if CAM stands in sharp contrast to "conventional" medicine.
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> Then I think about the word "complementary" and find myself wondering: What is so new or radical about the notion of one treatment complementing another? Does not the surgeon's work complement that of the internist or dietitian who is seeing the same patient? Has this not always been the case? I find myself leaning toward the conclusion that the term "complementary" became popular as a way to make more palatable to conventional practitioners whatever is truly revolutionary, and therefore perhaps threatening, about CAM.
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> My attention then turns to the word "alternative." Again, the initial impression is one of a dramatic change in the way things are done, and even perhaps conceptualized. How novel and exciting! Then I realize that the next step in the evolution of theory and practice is always the "alternative" to what is current, and in this sense is always revolutionary. The germ theory of infectious disease, before it became accepted, would be an example of alternative medicine. Acupuncture is currently on the threshold between CAM and conventional medicine, and will soon be absorbed into mainstream practice. Homeopathy is not far behind.
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> So now I begin to wonder what is fundamentally new in CAM. I find a clue in the way I tend to grind my teeth when I see a reference to "evidence-based" alternative treatments. The clue is in the implied nature of the evidence; it is *objective* evidence. Treatments such as acupuncture, homeopathy, herbal remedies, Reiki, and even prayer are subjected to the acid test of randomized double-blind controlled trials. Those that show statistically significant treatment effects compared to control groups are now (objectively) "evidence-based" and therefore accepted treatments.
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> What has not changed is the nature of the evidence that is acceptable. It must be objective evidence. I would propose that what is truly revolutionary about CAM is not the interesting and innovative treatments it investigates, but rather its challenge to the exclusive use of objectivity in determining treatment.
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> Enter subjectivity. When I started working on my Ph.D. in psychology 35 years ago, psychology was increasingly proud of being an objective science. I remember how discussions of complex clinical situations were often met with an enthusiastic assertion from one of the discussants: "We've got data on that!" Translation: there is published objective evidence that points toward an answer to the question at hand. However, the other phrase that often came up in such discussions was in the form of a question: "What's your clinical intuition?" The word "clinical" was really superfluous, and was only used to lend a certain professional tone to the discussion. The point is that intuition was valued as much as objective evidence.
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> Intuition, whether glorified as "clinical" or not, is clearly a form of *subjective* evidence. To be used as a basis for treatment decisions, it must be valued and cultivated. It is precisely this valuing of subjectivity that constitutes the truly revolutionary element within CAM.

Although I did not state it at this time, I was implying that what is significant about CAM is the fact that it takes psychology seriously. Psychology is the study of the psyche, which in the Greek tradition was presumed

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