

Guest Editorial

Complementary therapies in health care

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Abstract

In the past two decades, complementary therapies have grown in popularity in Western countries. The interest in complementary therapies could be explained by a “new consciousness” and the shift to a postmodern society. These therapies, embracing holistic practice, are derived from traditions of Eastern healing. There are many advantages of the complementary therapies that are playing a therapeutic role in the health care of individuals and, through the use of such therapies, nursing is developing a richness in holistic care. However, there are still barriers to be overcome; namely, the reluctance to accept complementary therapies in many contemporary healthcare settings. Through research and education, these barriers can be overcome.

Key words

complementary therapies, healing, health care, holistic practice, nursing.

INTRODUCTION

We are at a stage in health care when it is no longer reasonable to dismiss complementary therapies as ineffective in the provision of health care. In this editorial, I provide a contemporary overview of the issues in the use of complementary therapies and argue that their use has now reached a status where they can be considered to be an important part of health care in providing an uninvasive and holistic complement to health care.

“Complementary therapies” is a broad term encompassing those therapies that promote health and well-being and invokes a philosophy of mind–body connection. Such therapies are also often referred to as “complementary and alternative medicine” (CAM). Complementary and alternative medicine is defined as “those healing practices, technologies, perspectives and products (within a given country and time) that are not an established component of conventional medicine” (Adams, 2007: xix). Given the developments towards integrative medicine and therapies within Western countries over the past decade, there has been much debate and consideration about the terminology of CAM (Leach, 2010). I prefer to use the term “complementary therapies” rather than CAM, as the latter term has the potential to encourage a divisive discourse. It may be suggested wrongly that these therapies are used in place of conventional medicine and are separate from mainstream health care. The other argument for not calling them “alternative” therapies is that many of these therapies have been around for longer than traditional Western medicine. Even the term “traditional medicine” can be confusing as it can refer to not only Western medicine but also to indigenous traditional medicines, such as Thai herbal

therapies and bark remedies that originate from Australian indigenous Aboriginal culture.

Complementary therapies encompass a wide group of therapeutic interventions, involving over 1800 modalities, such as massage, aromatherapy, music, reflexology, visualization, meditation, Reiki, Bowen therapy, Alexander technique, Ayurvedic medicine, Chinese medicine, Australian bush flower essence therapy, homeopathy, and yoga. Not all these therapies are used in healthcare practice, but there are some, such as massage, aromatherapy, and visualization, that are being used and are leading to very positive research findings from studies and feedback from patients (van der Riet & Mackey, 1999; Mook & Woo, 2004; Burden *et al.*, 2005; Maddocks-Jennings *et al.*, 2005; Wahbeh *et al.*, 2008; van der Riet *et al.*, 2011b).

Historically, complementary therapies have been used for centuries in non-Western societies; however, there is now evidence of an escalating increase in usage in Western countries (Blackmer & Jefromova, 2002; Laures & Shisler, 2004; Leach, 2010). Such usage in developed countries, like Australia, UK, Germany, the Netherlands, France, and Finland, ranges from 25% to 75% (Laures & Shisler, 2004). In the USA and Japan, it has been reported that 50% of the population has used complementary therapies as a personal healthcare choice at least once during a 12 month period (Leach, 2010). The highest level of use has been in physical modalities, such as massage, chiropractic, and biological-based therapies, such as dietary supplements and herbal therapies (Leach, 2010).

Complementary therapy usage in the West has been influenced by Eastern philosophies, the spirituality of Buddhism, mindful meditation, and the neo-Hindu religious movement involving transcendental meditation (TM) that engaged individuals with a “new consciousness” in the 1960s through to the 1980s. In the 1960s, the popular culture of The Beatles

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brought attention to the practice of TM. Their spiritual leader or “guru” was the famous Mahesh Prasad Varma (1914–2008), known as “Maharishi Mahesh Yogi”, also known as the “Gigging Guru”, who conducted world tours on TM (Maharishi Foundation, 2010a). Many young persons travelled to India to submerge themselves in movements that sought to achieve a higher level of consciousness (Maharishi Foundation, 2010a). Within Western countries, training programs in TM became popular with a wider cross-section of society and TM trainers introduced the philosophy and practice of TM over several weeks for high fees. However, this type of meditation was, and still is, very expensive. I can recall making inquiries in the 1980s into doing this type of meditation and being discouraged because the cost of a 6 week program was \$A1600.

One might ask why such interest in complementary therapies? This could be explained by a “new consciousness” and the shift to a postmodern society, with individuals feeling more empowered and desiring more control over their health and therefore taking more personal responsibility for their health. It is often the case that the biomedical model does not holistically deal with the illness crises that the individual experiences, creating a loss of satisfaction and faith in conventional medicine. Consequently, more persons are turning to complementary therapies in the hope that they will have a fail-safe method and cure. This is a growing phenomenon that the medical profession and health professionals must acknowledge. Nowadays, with the advent of increased and advanced technology, individuals have greater access to information (Rankin-Box, 2004) and access to high-quality health information on the Internet about the possible choices and risks. There is also a stronger focus on disease prevention and lifestyle change to ensure good health, along with a preference for the “natural” and, in some cases, a rejection of the “technical”. The desire for the “natural” can have the effect of positioning oneself to take greater responsibility for one’s health and, in doing so, to exercise personal control.

A feature of improved health care has been a longer life span and a critical facet of this means aging populations in many countries. There is now a greater prevalence of chronic illness (Coulter & Willis, 2007) in the elderly and governments are challenged by not being able to financially sustain high healthcare costs. I argue that complementary therapies offer an uninvase approach to health care and potentially a way of managing some of the financial burden of chronic illness. There is a growing testimony that complementary therapies can make a significant cost-effective contribution to the health of the community, especially in relation to chronic disease management, well-being, and the prevention of disease (Adams, 2007). Furthermore, the use of complementary therapies is founded on a belief in holism and can assist disciplines, such as nursing, to develop a richness in holistic care.

The reported benefits of complementary therapies are numerous and include: more choices to assist individuals to feel in control of their well-being and so provide a sense of independence and confidence; the promotion of calmness and relaxation; an improvement in sleep patterns; a reduction of depression; and the potential for an early discharge from

hospital (Ernst *et al.*, 2008). There is also the potential to improve person-centeredness and therefore to improve the nurse–patient relationship.

In particular, meditation is now playing a significant and therapeutic role in the health care of individuals and there is increased interest in the use of meditation to deal with chronic symptoms, such as pain (Goyal *et al.*, 2010). Furthermore, research into meditation has demonstrated efficacy in reducing the debilitating symptoms of anxiety (Roemer *et al.*, 2008), depression (Teasdale *et al.*, 2000), substance abuse (Bowen *et al.*, 2006), eating disorders (Tapper *et al.*, 2009), and chronic pain (Grossman *et al.*, 2007). Regarding substance abuse, it has been reported that the influence of TM helped to wean The Beatles off the drug, LSD (Maharishi Foundation, 2010b). Generally, meditation has been credited with improving individuals’ well-being and therefore their quality of life (Carmody & Baer, 2008). A recent quantitative study reported that meditation leads to an increase in the brain’s gray matter density, potentially improving learning and memory and regulating emotions, such as depression and mood swings (Holzel *et al.*, 2011).

What of the barriers to complementary therapies in health care? I argue that a big barrier is the reluctance for institutions to accept these therapies as part of health care, as not all systems support their use. For example, a new nursing graduate reported recently to me that, at the hospital where she worked, complementary therapies were not encouraged nor supported. My initial attempt to establish a complementary therapy elective at a university in Australia was refused by a teaching and learning committee because it was not supported by the various healthcare disciplines involved; the strongest barrier being the discipline of medicine. Medical dominance often has been considered to be a problem when innovative uses of complementary therapies are proposed in practice. Coulter and Willis (2007) made the point that, historically, medicine around the world has tended to guard the right and power of doctors’ decision-making on all aspects of health care. As a result of this medical dominance, complementary therapies have been limited in relation to opportunities for education and research in our universities and healthcare institutions (Saks, 2003; Baer, 2006; Coulter & Willis, 2007). I can recall several years ago having to request permission from doctors on the stipulation of an ethics committee to be allowed to involve patients in a study on preoperative massage and several doctors refused to have their patients be involved in the study. Research has indicated that many patients do not advise their doctors about their use of complementary therapies (Moolasarn *et al.*, 2005), presumably because they do not believe that their doctor will agree to their use. This has the potential to undermine the doctor–patient relationship and, in some cases, to hide any deleterious cross-over effects in care delivery.

Clearly, there is a need to strengthen the dialogue between the medical profession and those who are delivering complementary therapies. Progress is being made, with some universities in the USA and the UK offering complementary therapy courses in the curriculum for medical students (Forjuoh, 2003; Smith, 2008). In Australia, there is the beginning of similar plans, although at this stage at my own

university, there has not been any enrollment yet from medical students into the open elective that the university offers on complementary therapies for undergraduate healthcare students. Within the medical profession, however, there are some who espouse and support the use of complementary therapies, as shown by the establishment of Australasian Integrative Medicine Association. Other community institutions in Australia, such as Cancer Council New South Wales, now produce resource material for persons with cancer and their family and friends on complementary therapies and support the use of some complementary therapies, such as meditation, visualization, and massage (Cancer Council New South Wales, 2009).

Many nurses have complained to me that complementary therapies are too time-consuming. However, my response is that there are many opportunities to include these in their practice. Sometimes, it might involve only a few minutes of massage while turning a patient and that might make the difference to the patient's comfort. There have been other complaints that some complementary therapies are too expensive, a case in point being TM, and that many therapies do not attract rebates from government-funded healthcare programs or private health insurance.

There also have been complaints that there is not enough rigorous research into complementary therapies (Smith, 2009). However, I would argue that this is changing, as rigorous research now is being done to investigate the efficacy of complementary therapies in health care. For example, yoga, with its origins in India, is an ancient discipline that dates back to 2000 BC and has been shown to improve the physical balance and gait function of the elderly (DiBenedetto *et al.*, 2005; Brown *et al.*, 2008). Recent quantitative research has demonstrated that yoga has been beneficial for breast cancer patients in reducing their level of anxiety and in managing the treatment-related symptoms, therefore improving their quality of life (Rao *et al.*, 2009; Vadiraja *et al.*, 2009). In my own experience with breast cancer, I was doing yoga and meditation shortly after my breast surgery (in fact, 1 week later) and throughout my radiation program. The side-effects of radiation treatment include fatigue, skin changes with burns, pulmonary symptoms, anxiety, and depression (Vadiraja *et al.*, 2009), but I did not suffer from any of these during radiation treatment.

There is also the claim that there is a lack of education regarding complementary therapies (Smith, 2009). However, this also is changing, as more educational institutions are more willing to include complementary therapies in their curriculum. Adams (2007) reported that there are university-based pockets of activity in countries, such as Australia, UK, and USA. Furthermore, also reflecting a change of educational practice is the scholarly emergence of peer-reviewed journals that focus just on complementary therapies (Adams, 2007). Such journals include high-impact journals, such as *Complementary Therapies in Medicine* and *Journal of Alternative and Complementary Medicine*.

Some nursing and midwifery undergraduate programs in Australia now offer complementary therapies as an elective, where the students investigate their efficacy and validity in health care (van der Riet *et al.*, 2010a). In 2009, the School of

Nursing and Midwifery at The University of Newcastle (Newcastle, NSW, Australia) for the first time offered an elective on complementary therapies for not only nurses, but for all students studying health disciplines. The reasons for introducing this course were numerous, including the recognition that, with the increased use of complementary therapies, I felt that nurses and other health professionals need to be familiar with specific practices so that they can assist their clients to make informed decisions in the use of these therapies. Importantly, there was a need to ensure that these practices are safe for patients (McCabe, 2005; Maddocks-Jennings *et al.*, 2005; Smith, 2008; 2009). Nurses can play a significant role in assessing patients' use of complementary therapies (Halcon *et al.*, 2003), which can create opportunities for nurses to have a deeper understanding of their patients' needs and more holistic and innovative approaches to their care (Smith, 2009).

We have much to learn from Eastern countries, such as Thailand, about the application of complementary therapies. In Thailand, the use of mind-body-energy therapies, such as massage and meditation, along with biologically based therapies, such as herbal therapies, is common practice in health care. I arranged a 2 week study tour, linked to the open-course elective (as indicated earlier in this editorial), entitled "Complementary Therapies in Healthcare". I planned the study tour so that the students from The University of Newcastle could experience the culture of the country and study in person the local complementary therapies in health care.

The tour provided a variety of cultural and health-related activities, presented through lectures and workshops, on the use of complementary therapies in various settings, such as a birthing suite, during community health promotion days, and in a rehabilitation center in which complementary therapies were used in the patients' treatment. The students observed practical demonstrations of Thai massage, practised the observed methods on each other, learnt about the use of herbal therapies that were for the patients' benefit in the rehabilitation center, and were introduced to Vipassana meditation. The meditation was presented by a Buddhist monk and involved both a sitting and a walking meditation. The undergraduate students gained an international perspective on how other healthcare institutions apply knowledge and skills in support of health care.

The following comment from a student about the cultural study tour demonstrates that the experience provided both insight and a positive appreciation of how massage and herbal therapies can provide comfort and good outcomes for laboring women and patients who have experienced a stroke:

The cultural tour to Thailand was a real eye-opener for me. There were many highlights, although two stand out for me. Firstly, the visit to the maternity ward was an experience I will never forget. I learnt that pain can be controlled, not only by medication but [by] relaxation and a feeling of being nurtured [by massage]. The beautiful young women were so serene, lying on their sides with the nurses giving them Thai massage. The rehabilitation center, where they used both traditional remedies

[herbal therapies and massage] and modern technology to improve the health of stroke sufferers, was a highlight during the 2 weeks.

ETHICAL AND LEGAL CONSIDERATIONS IN RELATION TO COMPLEMENTARY THERAPIES

With all healthcare practices, there are ethical and legal considerations. To be in a situation of care is to be in a position of some vulnerability; thus, health professionals need to be alert to patients' vulnerability. The principle of beneficence ("to do good") is one that requires health professionals to act in ways that benefit their patients. Moreover, as health professionals, we need to consider the legal issues of the scope of practice, involving the competence to practise. In order to be safe health professionals who are practising complementary therapies, nurses and other health professionals need to have the theoretical and practical skills, along with good interpersonal skills, providing confidentiality and privacy, and always ensuring that informed consent is gained. In our complementary therapy elective course at The University of Newcastle, we address these issues. The students also reflect on the general issues surrounding the growth and practice of complementary therapies.

Nurses are at the forefront of integrating complementary therapies into practice, ensuring a more holistic approach to care and that such therapies are consistent with a patient-centered ideology. Good clinical decision-making is needed when using complementary therapies, which must be incorporated within a framework that involves good interpersonal skills, assessment, planning, diagnosis, application, and review (Leach, 2010).

CONCLUSION

Complementary therapies offer a holistic approach to health care in relation to the symptom management of chronic disease and within preventive health care. There is now considerable clinical evidence to support the efficacy of complementary therapies; however, there is still much work to be done in this area so that healthcare institutions in the West accept them as a normal part of contemporary healthcare practice. Universities can make an important contribution to our knowledge and skills in the use of complementary therapies through various forms of academic research. In my own case, I am supervising our first honor-degree student who is investigating complementary therapies (incidentally, she was one of my students from the first study to Thailand), as well as a doctoral student who is exploring tai chi and yoga in a residential aged-care setting. The more that we encourage our students and clinicians to research in the area of complementary therapies, the stronger the knowledge base will be in this area and the more evidence that will be garnered in order to convince the sceptics that complementary therapies can make a difference. Importantly, such research has the potential to transform health care by providing equitable and improved health outcomes for all in society.

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