

An evaluation of a complementary therapy service showed that these therapies can improve overall wellbeing of patients with cancer and their carers

# Effects of complementary therapies in cancer care

## In this article...

- › Description of the complementary therapy service
- › How the service is evaluated
- › Discussion of findings

## 5 key points

**1** All NHS services should be subject to ongoing evaluation

**2** The primary roles of service evaluation are to analyse patient views, wellbeing and outcomes, and measure symptom management

**3** Providing individualised treatment evaluation can lead to personalised treatment changes

**4** Perceived success of complementary therapy is dependent on other outcomes, such as effectiveness of other treatments

**5** Individualised qualitative evaluation methods are as vital as undertaking quantitative studies

**Author** Julia Briscoe is head of complementary therapies; Neil Browne is a senior complementary therapist; both at Whipps Cross University Hospital, Barts Health Trust, London.

**Abstract** Briscoe J, Browne N (2013) Effects of complementary therapies in cancer care. *Nursing Times*; 109: 41, 18-20. Evaluating practice is central to any NHS service. Evidence-based approaches are essential to ensure that services are run effectively, develop according to need and continue to be commissioned.

A complementary therapies service was introduced at Whipps Cross University Hospital for patients with cancer and palliative care needs. The service was evaluated using an evaluation tool.

Findings from the evaluation covered symptom management, wellbeing and therapeutic modalities. It is important to undertake individualised qualitative evaluations as well as quantitative studies.

Complementary therapies are commonly used by patients after a cancer diagnosis (Anderson and Taylor, 2012) and several NHS services provide them, mostly funded through charities. Many of these services provide treatments for patients with cancer or those receiving palliative care.

Evidence demonstrating efficacy is vital in all areas of healthcare, including complementary therapies, to justify their provision. The introduction of personal health budgets, which allows people to purchase complementary therapies (Wilkinson, 2012), will almost certainly require robust evidence to support complementary therapies if requests for these are to be authorised by clinical commissioning groups.

The National Institute for Clinical Excellence (2004) issued guidance on complementary therapies in its manual for supportive and palliative care services for adults with cancer. It states that those involved in providing complementary therapies in the NHS should make every effort to contribute to their ongoing evaluation. This is supported by the National Cancer Action Team (2009), which states that "all therapies provided to patients are subject to ongoing assessment of evidence, efficacy and safety". The Royal College of Nursing (2003) agrees, stating that complementary therapy providers should be able to demonstrate efficacy through evaluation and that tools for this should be identified.

### The service

The complementary therapies service at Barts Health Trust was set up to meet the needs of palliative care patients, and quickly expanded to include those with any cancer diagnosis. It aims to help patients and families regain a sense of control during a serious, potentially life-limiting diagnosis, and to manage anxiety in those no longer requiring treatment.

A range of therapies are offered including aromatherapy, massage, reflexology, shiatsu and homoeopathy. They are provided on a one-to-one basis for patients and, to a lesser extent, for carers; a weekly relaxation class also serves as a drop-in support group. We support self-help in a range of ways, from providing simple items, such as aromasticks, to offering training on mindfulness and relaxation techniques.

We initially received three years of charitable funding, which, based on the service's success, was extended by two years. Treatment costs in our service are substantially



*“There is a huge need to provide physical care in mental health”*

Martin Steggall ▶ p24

**TABLE 1. PERCEIVED CHANGE ACCORDING TO SPECIFIC CATEGORY**

	Completed forms	MYCaW 1 Pre	MYCaW 1 Post	Change %	MYCaW 2 Pre	MYCaW 2 Post	Change (%)
<b>Patients</b>	198	4.71	2.99	36.52%	4.56	2.99	34.43
Chemo support	17	4.17	2.76	33.81%	3.46	2.37	31.5
Digestive	11	4.81	2	58.42%	4.55	2.50	45.05
Emotional	65	4.69	3	36.03%	4.69	3.12	33.48
Pain	61	4.86	3.1	36.21%	4.63	3.15	31.97
Respiratory	6	5.33	3.33	37.52%	4.5	3.25	27.78
Skin	9	4.55	2.11	53.63%	4.28	3	29.91
Sleep	29	4.67	3.37	27.84%	4.69	2.84	39.45

lower than the average costs of other treatments in the NHS (Ernst, 2008). This can be misleading for those commissioning services and may deter them from commissioning a service altogether. Yet costs per treatment are low because many are provided by volunteers (honorary therapists), while we source low-cost but high-quality products and group work.

### Therapies

Aromasticks are supplied to the service as blank nasal inhalers, which aromatherapists use to create bespoke blends for patients; these can help with anxiety, panic attacks, sleep disturbance or breathing difficulties (Stringer and Donald, 2010). The service has had notable success in the treatment of anticipatory or chemotherapy-induced nausea (Table 1).

Relaxation techniques, used to improve quality of life and aid stress management, include deep breathing, progressive muscle relaxation and creative visualisation. Music complements the sessions (Hanser et al, 2006). Progressive muscle relaxation involves tensing then releasing muscles; it is based on the premise that the relaxation leads to “relaxation of the mind” (Conrad and Roth, 2007). In guided visualisation, participants are led through a process of imagining sensations associated with relaxing environments or situations. The sessions, which also create an informal support group for patients and carers, may lead to a greater sense of control and improve communication (Roberts et al, 2002).

From its inception, the service recognised the need to maintain a respected profile within the trust, and has robust, evidence-based policies and protocols that have been ratified through clinical governance systems and are regularly updated.

### Evaluation of the service

National guidelines suggest the main purposes of service evaluation are to analyse

patient views, wellbeing and outcomes, and measure symptom management (Tavares, 2003).

The Measure Your Concerns and Wellbeing (MYCaW) questionnaire meets these needs, and was designed specifically for evaluating supportive cancer care interventions, including complementary therapies (Paterson et al, 2007; Polley et al, 2007). We use MYCaW to identify patients’ own priorities for interventions and enable them to offer personalised feedback. Its results can provide vital data about their experience and symptom management, particularly how this changes over time and how other aspects of patients’ lives are affected.

Seers et al (2009) argue that a combination of qualitative and quantitative data may help to build a robust and generalisable understanding of the role of

complementary therapies and cancer support care and be an invaluable component of internal service evaluation.

### Data evaluation

The MYCaW questionnaire has generated a local evidence base that shows perceived improvements in symptoms following complementary treatments.

The evaluation of outpatient clinics is patient led and personalised; it asks patients to assess the effects of two primary concerns and their perception of current wellbeing on a 0-6 point Likert scale ([tinyurl.com/BristolUni-MYCaW](http://tinyurl.com/BristolUni-MYCaW)). Our data does not include every patient as it is not always appropriate or possible to administer the questionnaire.

The MYCaW also allows patients to reflect on treatment and other factors that

**TABLE 2. PERCEIVED CHANGE IN WELLBEING**

Wellbeing	Completed forms	Avg pre-treat rating	Avg post-treat rating	Change (%)
General	249	3.99	2.77	30.58
Aromatherapy	64	3.73	2.28	38.87
Homoeopathy	22	3.82	3	21.47
Massage	17	3.53	2.71	23.23
Shiatsu	16	4	2.31	42.25
Reflexology	130	4.20	3.03	27.86
Patients	198	3.91	2.74	29.92
Carers	51	4.39	3.02	31.21
Male	61	3.75	2.51	33.07
Female	188	4.07	2.85	29.98
Age 25-34	7	4.43	3.57	19.41
Age 35-44	37	3.59	2.30	35.93
Age 45-54	56	4.41	3.31	24.94
Age 55-64	68	4.02	2.65	34.08
Age 65-74	49	3.94	2.81	28.68
Age 75 +	32	3.78	2.44	25.45

TABLE 3. PERCEIVED CHANGE BY CATEGORY

	Completed forms	MYCaW 1 pre	MYCaW 1 post	Change %	MYCaW 2 pre	MYCaW 2 post	Change %
General	249	4.71	2.99	35.52	4.56	2.99	34.43
Aromatherapy	64	4.52	2.46	45.58	4.52	2.71	40.04
Homoeopathy	22	4.95	3.4	31.31	3.90	2.76	29.23
Massage	17	5	3.11	37.80	4.25	3.33	21.65
Reflexology	130	4.72	3.21	31.99	4.76	3.19	32.998
Shiatsu	16	4.62	2.68	41.99	4.58	2.71	40.83
Patient	198	4.65	2.96	36.34	4.52	2.92	35.4
Carer	51	4.84	3.21	33.68	5.1	3.51	31.18
Male	61	4.75	2.63	44.63	4.3	2.8	34.88
Female	188	4.7	3.11	33.83	4.63	3.04	34.34
Age 25-34	7	4.42	3.21	27.38	4.8	4	16.67
Age 35-44	37	4.54	2.64	41.85	4.48	2.80	37.5
Age 45-54	56	4.88	3.29	32.58	4.59	3.04	33.77
Age 55-64	68	4.8	3.09	35.63	4.54	2.77	38.99
Age 65-74	49	4.56	3.04	33.33	4.71	3.2	32.06
Age 75+	32	4.61	2.59	43.82	4.27	2.85	33.26

contribute to their final score. They often cite circumstantial issues, such as bereavement or disease progression, or positive aspects such as perceived improvements in symptoms not covered by the evaluation.

Using the MYCaW provides details about which therapeutic interventions have the greatest impact on the perception of specific symptoms (Tables 1 and 2). The data indicates that symptoms are perceived to improve by an average of just over 30% in both patients and carers (Table 2).

### Discussion Wellbeing

The evaluation tool looks at patients' perceptions of "wellbeing"; although no definition of wellbeing is given, the data shows patients interpret how they feel overall physically, emotionally and spiritually.

Where the data has been broken into treatment categories, the numbers of forms collected to date are too small to be truly indicative but make interesting comparisons. There was some debate about why younger patients (age 25-34) perceived only a 19% improvement, which was significantly lower than in other age groups. Younger patients may be under greater pressure to make decisions about treatments that could affect a future they had not fully considered. For example, those with a short prognosis may experience more profound effects on wider life issues such as relationships, fertility and career.

### Patients

Over time, a larger number of completed forms should enable us to draw firmer conclusions. For now, patients appear to perceive complementary therapies as enhancing compassionate care and providing comfort during an extremely difficult clinical experience. Complementary therapies may be a confirmation of compassionate care (Billhult et al, 2007).

Perceived success of complementary therapy interventions depends on outcomes. Clearly, outcomes improve when chemotherapy has been successful, and decline when patients receive bad news.

Based on the current data, we propose that complementary therapy interventions make a significant positive difference, regardless of gender, age or patient/carer status. Further studies should be conducted by researchers independent of complementary therapy professions.

### Conclusion

Health professionals have a responsibility to evaluate their services, and may do this using standardised evaluation tools such as MYCaW; our data is being used to justify continued funding of salaried posts.

As well as providing evidence for effectiveness of interventions, evaluation may help service providers to adopt patient-led approaches. Patient symptom scores may indicate a need to change treatment plans midway through a course of treatment.

Working collaboratively with patients may help to give them back some control over managing their health, which may be particularly useful for those who feel their body is out of control. However, Evans et al (2011) suggest that patients may reject this because of a reluctance to take responsibility for outcomes. It is important to keep this in mind when working in cancer survivorship, which is a part of our service.

Although the evidence base for complementary therapies in integrated healthcare is emerging, debate continues over the need for high-quality randomised controlled trials. We also need an evidence base that includes high-quality qualitative data. **NT**

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