



The effect of self-selected complementary therapies on cancer patients' quality of life and symptom distress: A prospective cohort study in an integrative oncology setting



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ABSTRACT

Objective: To examine the effectiveness of a multifaceted complementary therapies intervention, delivered in a systematic manner within an Australian public hospital setting, on quality of life and symptom distress outcomes for cancer patients.

Methods: Adults receiving treatment for any form of cancer were eligible to participate in this study. Self-referred participants were offered a course of six complementary therapy sessions. Measures were administered at baseline, and at the third and sixth visit. The primary outcomes were quality of life and symptom distress. Linear mixed models were used to assess change in the primary outcomes.

Results: In total, 1376 cancer patients participated in this study. The linear mixed models demonstrated that there were significant improvements in quality of life and significant reductions in symptom distress over six sessions. Body-based therapies demonstrated significantly superior improvement in quality of life over counselling, but no other differences between therapies were identified. Reduced symptom distress was not significantly associated with any particular type of therapy.

Conclusion: A self-selected complementary therapies intervention, provided in an Australian public hospital by accredited therapists, for cancer patients significantly improved quality of life and reduced symptom distress. The effect of this intervention on quality of life has particular salience, since cancer impacts on many areas of people's lives and impairs quality of life.

1. Background

Cancer patients commonly use complementary medicine therapies as an adjunct to standard care. A systematic review reported that the point prevalence of complementary therapy use among Australian cancer patients was 40%, which reflected the pooled prevalence across all countries.¹ The results of the systematic review also found that there

was a consistent trend towards increased use of complementary therapies among cancer patients, with the prevalence shifting from 25% in the 1970's and 1980's, 32% in the 1990's, to an estimated 49% after 2000.¹ The ongoing rise in the use of complementary medicine for cancer by the general public has led to some conventional oncology services implementing strategies that might assist in meeting this increase in demand.²

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Integrative oncology has emerged in response to cancer patients increasing use of complementary medicine.² Such treatment aims to reduce the side effects of standard care, improve emotional health and quality of life, and in some instances augment the effect of standard care.^{3,4} The provision of integrative oncology is often informed by a patient-centred approach, in which different types of health professionals work collaboratively in order to care for the whole person and promote health and wellbeing.⁵

Evidence-based clinical guidelines have been developed for integrative oncology. These guidelines report that cancer patients may benefit from the use of the following types of complementary therapies: mind-body techniques (meditation, yoga, tai chi, relaxation techniques); body-based practices (massage, reflexology, Alexander technique, Pilates); energy therapies (external qi gong, Reiki, polarity therapy, pranic healing); and acupuncture.⁶ Benefits that result from the use of these complementary therapies varies from therapy to therapy, but typically include reduced pain, fatigue, and anxiety, along with improved quality of life.^{3,4,7} The strength of the supporting evidence also differs between complementary therapies, but it is important to note that all of the aforementioned therapies have been shown to be safe for cancer patients to use.⁶

The effectiveness of complementary therapies for the management of cancer symptoms and standard care side effects has typically been established in studies involving the use of a single complementary therapy. However, in everyday settings, integrative oncology takes the form of a complex intervention, commonly comprising several types of therapies.^{5,6} Limited evidence is currently available about the effectiveness of integrative oncology services.^{2,8–10} In Western Australia, a new innovative approach to integrating complementary therapies within the acute care hospital in addition to standard care, was instigated through the establishment of a cancer support centre in 2001.¹¹ Our study addresses the literature gap through establishing the effectiveness of a multifaceted complementary therapies intervention, delivered in a systematic manner through this centre situated within an Australian public hospital setting, on quality of life and symptom distress outcomes for cancer patients.

2. Methods

2.1. Study design

A prospective cohort study was undertaken at a cancer support centre located within a public hospital in Western Australia. Ethical approval for this study was obtained from the Sir Charles Gardiner Hospital Human Research Ethics Committee.

2.2. Participants

Adults receiving treatment for any form of cancer were eligible to participate in this study. No other inclusion or exclusion criteria were applied. At the initial presentation to the cancer support centre, potential participants were informed about the nature of the study and required to provide informed written consent before being enrolled in the study.

2.3. Interventions

Self-referred participants were offered a course of six complementary therapy sessions. In each session, participants could select one therapy from a range that comprised body-based therapies, energy-based therapies, mind-body techniques, and counselling. All sessions were delivered by practitioners who: had undertaken a recognised training course in a particular therapy; had at least 12 months experience in providing a particular therapy; and undertaken a probationary period as a meet and greet volunteer at the centre.

2.4. Outcome assessment

Demographic and clinical characteristics data collected at baseline included age, gender, residential location, cancer type, cancer site, metastasis, in/out patient status, standard care received (chemotherapy, surgery, radiotherapy, medication), and presence of comorbidities. Administered at baseline and at the third and sixth visit, was a seven point global measure, which measured change in disempowerment; depression; anxiety; frustration; confusion; impaired coping; and worry. These measures were combined to form an overall quality of life score. In addition, the Symptom Distress Scale, scored on a five-point Likert scale, evaluated change in pain; fatigue; nausea; bowel problems; breathing difficulty; poor appetite; and impaired sleep.

2.5. Statistical analysis

Data were entered and analysed in Stata v.13. All data were reported descriptively. Separate linear mixed models were used to establish treatment effects for the outcomes of quality of life and symptom distress. Time (session one, three, and six) and treatment (mind-body techniques; body-based practices; energy therapies, and counselling) were modelled as fixed effects. Further details about the grouping the therapies is displayed in Table 1. ANCOVA was used to examine differences in the change in quality of life and symptom distress between different cancer types over six sessions. Participants were included in the ANCOVA analysis if they experienced only one type of cancer, and types of cancer were only included if there were more than 25 cases. Age and gender were entered as covariates in the linear mixed models and ANCOVA. Missing data were addressed by sequential regression multiple imputation.

3. Results

Data were obtained from 1274 participants. Fig. 1 displays the participant flow over the course of the study. The participants' characteristics are displayed in Table 2. Almost three quarters (74.5%) of the participants were female, the mean age was 55.3 (SD = 12.8) years, and most were outpatients (81.6%). Breast cancer was the predominant cancer type (42%; n = 535) and metastases were reported in 348 patients (27%). In terms of standard care, 12% were undergoing concurrent chemotherapy; 15%, concurrent radiotherapy; 26% had prior surgery, and 73% were not receiving active cancer treatment.

The results of the linear mixed model showed that the quality of life score improved significantly over six weeks (Table 3 & Fig. 2). Body-based therapies demonstrated significantly superior improvement in quality of life over counselling, but no other significant differences between therapies were identified. Numerous differences in improved quality of life were observed between different cancer types (significant differences displayed in Table 4). The largest improvements in quality of life were found for lung cancer and melanoma patients.

The linear mixed model for symptom distress established that it fell significantly across the six sessions (Table 3 & Fig. 3). Reduced symptom distress was not significantly associated with any particular type of therapy. Numerous differences in reduced symptom distress

Table 1
Grouping of Complementary Therapies.

Body-Based Therapies	Energy-Based Therapies	Mind-Body Based Therapies	Counselling
Aromatherapy	Reiki	Chi meditation	Counselling
Relaxation Massage	Pranic Healing	Creative Art Therapy	
Bowen Therapy		Breathe for Health	
Healing Touch		Tai Chi	
Cranio-sacral		Creative Visualisation	
Acupuncture		Music Therapy	

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