



## Why people seek complementary and alternative medicine before conventional medical treatment: A population based study



P. Thomson <sup>a,\*</sup>, J. Jones <sup>b</sup>, M. Browne <sup>c</sup>, S.J. Leslie <sup>d,b</sup>

<sup>a</sup> School of Nursing, Midwifery and Health, BG Bomont Building, University of Stirling, Stirling Campus, Stirling, FK9 4LA, Scotland, UK

<sup>b</sup> School of Nursing, Midwifery and Health, Centre for Health Science, University of Stirling, Highland Campus, Old Perth Road, Inverness, IV2 3JH, Scotland, UK

<sup>c</sup> School of Human, Health and Social Sciences, Central Queensland University, Bundaberg Campus, University Drive, Branyan, QLD, 4670, Australia

<sup>d</sup> Highland Heartbeat Centre, Cardiology Unit, Raigmore Hospital, Inverness, IV32 3UJ, Scotland, UK

### A B S T R A C T

#### Keywords:

Complementary and alternative medicine (CAM)  
Medicine  
Perceived control  
Health  
Spirituality

**Background:** Few studies explain peoples' intentions to use complementary and alternative medicine (CAM) before conventional medicine.

**Aims:** To examine the psychosocial factors associated with intention to try CAM before conventional medicine; to explore the predictors of initially seeking CAM in the adult population in Australia.

**Design:** A cross sectional survey.

**Methods:** 1256 adults were interviewed as part of 2012 Queensland Social Survey. Relationships were explored using logistic regression.

**Results:** 79% of respondents had used CAM in the last 12 months; 17.6% of people would try CAM before conventional medicine. Age, education, perceived control and spirituality predicted intention to try CAM before conventional medicine. People often sought CAM initially to improve their health and well-being.

**Conclusion:** Personal characteristics and psychosocial factors predicted intention to try CAM before conventional medicine. These factors need to be considered by doctors and other conventional health care providers as part of person centred approaches to healthcare.

© 2014 Elsevier Ltd. All rights reserved.

### 1. Introduction

In western industrialised countries the proportion of the general population that use complementary and alternative medicine (CAM) ranges from 10 to 52% [1–7] and this is increasing [8–10]. CAM treatments include a variety of approaches; practitioner delivered (e.g. acupuncture, homeopathy, reflexology, massage) and self care practices (e.g. homeopathic remedies, herbal medicines, vitamins), many of which are based on theories that differ from conventional medicine. [11] CAM users are more likely to be female [1,2,8,10,12–17]; middle aged [18,19]; employed [1,10]; have higher household income [1,3–5,8,10,14]; more education [1,8,13,14,20]; belong to certain ethnic groups [18,20]; and geographic regions [2,8,10,14,21], especially rural [22].

Poorer health status indicates the need for health care [23], but it also predicts CAM use [3,18,20,21,24]. Individuals with chronic health problems use more CAM, compared to healthier individuals

[4,14,19,23,25,26]. CAM use may be attributed to personal preference or choice and beliefs about the health benefits of CAM [2,27,28]. People with greater perceived control over their health are thought more inclined to use CAM [14,29], although there are some mixed findings from research [30]. Positive health behaviours such as not smoking, being physically active, managing stress, eating a healthier diet and avoiding excessive drinking are associated with the increased use of CAM [2,31].

Some individuals perceive health as a reflection of religious or spiritual beliefs [20,30], with self-rated spirituality but not religiosity associated with greater CAM use [30,32,33]. 'Post-modern' lifestyles and values, such as feminism, vegetarianism and spirituality positively predict CAM use. This suggests a philosophical mind-set that values holistic balance and personal growth [34]. Specifically, studies of practitioner delivered CAM have found that spirituality represents an important predictor in the delivery of CAM [32,33,35,36].

Openness to new experiences is another factor associated with increased CAM use [37,38]. This personality dimension is one facet of the well-established Five Factor Model [39], which describes the extent to which a person is open to new ideas, approaches and experiences [39,40]. Openness is associated with intelligence,

\* Corresponding author. Tel.: +44 (0) 1786 466396.

E-mail address: [patricia.thomson@stir.ac.uk](mailto:patricia.thomson@stir.ac.uk) (P. Thomson).

creativity, liberal social views, fantasy and a need to enlarge upon and examine experiences [41]. People high in openness tend to be more flexible, less conventional and less adherent to conventional belief systems. This trait is a distinct dimension [30], one not associated with increased conventional care use. Previous research has found openness to experience, spirituality and mood attention strong predictors of overall willingness to use CAM [38], and use of particular types of CAM [42]. Interestingly homeopathic practitioners themselves have been shown to score significantly higher on openness to new experiences [43].

People's decision to use CAM may be down to personal choice [2,27]. They may decide not to discuss their choice of treatment with conventional health care providers or they may see it as irrelevant to their conventional treatment [44,45]. However, it is important that doctors and other conventional healthcare practitioners know about their patients' use of CAM. Serious reactions can occur from herb or vitamin–drug interactions [1,4,8,44–48]. Evidence from the US, UK and Australia suggest non-disclosure of CAM use is high and it has not decreased in recent years [3,8,27]. As many as 77% of patients do not disclose their use of CAM to a medical practitioner [49,50]. The reasons for this are complex and include doctors' lack of inquiry [49], patients' fears about medical scepticism [14,25,37,48], or inability or help [48].

In summary, the knowledge and behaviours of conventional healthcare providers and patients themselves may militate against disclosure of CAM use. Non-disclosure of CAM by patients may be intentional or unintentional [14,37,49]. Every effort must be made to encourage more open exchanges of information and shared decision making [51], as part of person centred approaches to holistic and preventive healthcare [7,52]. Doctors and other conventional care providers need to be aware that the personal characteristics of individuals (socio-demographics, perceived health status) and psychosocial factors (knowledge derived from spiritual experiences and openness to new experiences) may influence peoples decision to seek CAM and when. Several previous studies as described have identified the predictors of CAM use. Still relatively little is known about why people seek CAM before conventional medical treatment. This study aimed to examine the psychosocial factors associated with intention to try CAM before conventional medic; to explore the predictors of initially seeking CAM in the adult population in Queensland, Australia. The term CAM is used in the study to indicate practitioner delivered therapies and self care practices, provided alongside or instead of conventional medicine.

## 2. Methods

### 2.1. Design and sample

A cross-sectional design was used to collect data on CAM as part of the 2012 Queensland Social Survey (QSS) [53]. A two-stage stratified sampling strategy was used to select households and individuals in Queensland. A computer programme was used to select, with replacement, a simple random sample of phone numbers. Within each contacted household, one eligible person was selected for interview based on age (18 years or older), sex (male or female) and availability. The survey estimates of sampling error for the total sample of 1256 showed this was accurate within  $\pm 2.8$  percentage points, at a 95% CI [54]. The most recent Australian Bureau of Statistics [55] census data was used for comparison with the 2012 QSS sample.

### 2.2. Measures

Socio-demographics, health status, health behaviours and chronic health problems were assessed as part of the 2012 QSS. We added seven questions/statements about CAM use (Appendix 1).

#### 2.2.1. Socio-demographics

Age was originally categorised as: 18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years and 65 or older (later recoded as under 55 and 55+ years to allow for additional statistical analysis). Marital status was classified as married, de facto (cohabitating), separated/divorced, widowed and single (recoded as married/partnered and unmarried/un-partnered). Employment was defined as being in paid employment in the previous week, categorised as employed (full-time), employed (part-time/casual), unemployed, retired/pensioner, student and home duties (recoded as employed and not employed/no response). Years of education, place of residence, household income and religion were identified. Country of birth was recorded as Australia or other.

#### 2.2.2. Perceived health status

General health was assessed using one item from the Healthy Days Core Module [56]. Physical health and mental health and combined physical and mental health were assessed by identifying the number of days people had not been good in the last 30 days and they were asked to report if they had a chronic health problem.

#### 2.2.3. Health behaviours

Smoking status, body mass index (BMI), daily fruit and vegetable consumption, fast food consumption and BMI calculated from self-reports of height (in centimetres) and weight (in kilograms) were identified by self-report. Alcohol consumption, considering all types of alcoholic beverages, was identified according to how many times during the past 30 days respondents had 6 or more drinks on an occasion [56]. Self-reported leisure-time physical activity was identified using the Active Australia physical activity measurement scale [57], recoded as sufficient (non-sedentary) if respondents had spent any time in physical activities (walking, moderate or vigorous intensity activities) in the week prior to the survey, or insufficient (sedentary) if they had spent no time in these activities.

#### 2.2.4. Complementary and alternative therapies

The CAM questions identified were derived from previously validated questionnaires [58] and from studies that have distinguished between people who have used CAM from those who have not [1,2,59], the reasons why people use CAM [4,12,19–21,25,28], including such factors as spirituality [30,32], perceived control over health [28] and openness to new experiences [37,38].

### 2.3. Data collection

Interviewing for the 2012 QSS (second round) began in October 2012 and it was complete by December 2012. Approval for the study was received from the Human Ethics Research Panel at CQUniversity before administration to the general public (Project: H10/06-121, QSS 2012). All subjects gave informed consent to the research.

### 2.4. Statistical analysis

All data analyses were performed using Predictive Analytics Software (PASW) statistics, version 19.  $P < 0.05$  was taken to indicate statistical significance. Descriptive statistics were computed for the CAM questions/statements. Bivariate relationships were examined between the following dichotomous outcomes: 1) Intention to try CAM before conventional medical treatment (agree/disagree) and 2) Reasons for initially seeking CAM (medical vs non-medical reasons), and socio-demographics, health status, health behaviours, sources of knowledge (i.e. spiritual experiences), perceived control over health, openness to new experiences, prescribing sources and chronic health problems (independent

Download English Version:

<https://daneshyari.com/en/article/2628534>

Download Persian Version:

<https://daneshyari.com/article/2628534>

[Daneshyari.com](https://daneshyari.com)