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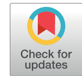
Review article

# Attitudes and beliefs that affect adherence to provider-based complementary and alternative medicine: A systematic review



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ABSTRACT

*Introduction:* Although a systematic review on the beliefs involved in the use of complementary and alternative medicine (CAM) has been conducted, there is research indicating that these findings may not be applicable to adherence. Thus, a systematic review was undertaken with the aim to identify the attitudes and beliefs towards CAM that affect adherence over time to provider-based CAM in adults.
*Methods:* A literature search was conducted in the default fields on the variations of 'adherence', 'compliance' and 'concordance'. They were combined with "complementary medicine", "complementary therapy", "alternative medicine" and "alternative therapy", and their plural forms. The search was executed in PubMed, Embase, IPA, PsycINFO, CINAHL, BNI, CENTRAL, AMED and OpenGrey. Inclusion criteria were applied, along with a modified Downs and Black Instrument. Narrative synthesis was performed on the data extracted.
*Results:* The search returned with 9387 records. Of these, seven studies were reviewed. Despite the lack of consistency in reporting and Downs and Black scores of 9–18, the findings overall appear to show that a positive attitude or belief in therapy as well as appreciation of the CAM is associated with adherence. To provide a framework of understanding, the factors extracted in this review can be mapped to the capability, opportunity, motivation and behaviour model which is applicable to conventional medication adherence.
*Conclusion:* Positive attitudes and the belief in treatment effectiveness were generally associated with adherence to provider-based CAM in the adult population studied within this review.

## 1. Introduction

Complementary and Alternative Medicine (CAM) has many definitions and is commonly accepted to be any form of treatment outside of conventional medicine, otherwise known as Western biomedicine [1]. It can include self-selection of vitamins and minerals to learning taijiquan from a master [1]. Adherence is defined as "the extent to which a person's behaviour − taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider" [2]. By this description, a practitioner must deliver treatment for investigation of adherence to occur and so only CAM therapies that were provider-based will be reviewed.

Adherence has been extensively studied in conventional medicine with numerous models developed to demonstrate the interplay of affecting factors [2]. In contrast, adherence within CAM has received little attention with only two models identified in the literature [3,4]. These are the dynamic extended self-regulation model and CAM Consumer Commitment Model [3,4].

The dynamic extended self-regulation model is an adaptation of two models [3]. It amalgamates the dynamic model of treatment perceptions and the common-sense model of self-regulation [5–7]. The dynamic extended self-regulation model begins with a situational stimulus, which separates into two streams, whereby one is for illness and the other for emotions [3]. Both have representations and treatment beliefs affecting coping procedures for their respective stream, leading to appraisal which is composed of four dimensions: perception of therapist, symptom change and therapy as well as the practical aspects of therapy [3]. Appraisal feeds back into coping procedures, representations and treatment beliefs in addition to the situational stimuli [3].

The CAM Consumer Commitment Model is composed of utilitarian and symbolic values that individually affect commitment to CAM which in turn reflects on these values. Commitment encompasses more than adherence to the advice offered and includes recommending CAM to others. Utilitarian values are comprised of positive outcomes, satisfaction and trust with CAM, while symbolic values are perceptions of beliefs being congruent with CAM [4].

The models were developed in recognition of factors unique to

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CAM. For example, the extra steps taken to seek CAM when conventional is usually the standard medical care offered by the government free or at a lower cost [4]. However, they were not systematically developed like the Capability, Opportunity, Motivation and Behaviour (COM-B) model which is applicable to conventional medication adherence [8]. Without the review of literature and consultation with experts followed by evaluation of the identified models to produce an overarching one that is then reliability tested, the CAM models are not as robust [9].

The COM-B is composed of three components that are each divided into two sub-components. The Capability, Opportunity and Motivation components directly affect Behaviour, while Capability and Opportunity additionally influence Motivation. Capability includes aspects that are psychological and physical for performing the behaviour. Opportunity could also be physical, being offered externally, but social as well, which would be cultural beliefs. Motivation can be reflective: evaluating and planning. It can be automatic: emotional or impulsive too [9].

When the COM-B is compared with the CAM models, the COM-B can be seen to incorporate both CAM models and more. The CAM models mainly contain factors classified as reflective motivation in the COM-B, but none for the physical capability and social opportunity sub-components. However, the CAM Consumer Commitment Model could be considered to have embedded social opportunity within expression of commitment to CAM. Nevertheless, it does not offer any factors for listing under the physical opportunity sub-component of the COM-B. Thus, the COM-B will be more effective for modelling the attitudes and beliefs that affect adherence in this review.

The reasons motivating CAM use can be different in those who are adhering initially versus continually. Patients often begin using CAM because it was recommended by family or friends, which appears to be a greater motivator for initial adherence than continued [10]. Comparatively, experiencing conventional medicine treatment side effects was a greater motivator in continued adherence [10]. The lack of effective conventional medicine treatment is another common reason for consulting a CAM practitioner [10,11]. Dissatisfaction with conventional medical care is as well, but more so initially than for continued adherence [11,12]. Dissatisfaction was with specifically the technical quality of conventional medicine [10]. However, the preference for patient centred care features prominently in CAM patients. It was found to be the only predictor of continued adherence by Sirois and Purc-Stephenson [10]. In the same study, greater symptom distress along with conventional medicine dissatisfaction and preference for patient centred care to a lesser extent were the three predictors for initial adherence [10]. However, medical needs were found to be the main driver of continued adherence in an earlier study [11].

Bishop et al. [12] describes the experience patients have of CAM to be the most important influence in deciding to maintain its use with a practitioner. The experience can be characterised by affective, cognitive, interpersonal and physical dimensions in reference to needs and expectations, along with financial limits. Experiences did not necessarily have to be positive, but patients usually returned to therapy because needs were previously met and expect they will again. Other reasons were for treatment of a particular problem that was physical, improvement of well-being and congruency of health beliefs with CAM [12].

According to a systematic review, where demographic variables and health status were controlled, people were more likely to use CAM if they believed in an internal locus of control, greater participation when decision making, psychological factors as a cause of illness, holism, treatments that are natural, spirituality and unconventionality [13]. The inference is that people who use CAM believe they can control their illness by adopting an active role and require health professionals to understand and address more than the biomedical model of illness, incorporating spirituality and natural treatments.

As there is no summary in the literature identifying the attitudes and beliefs towards CAM that affect adherence to provider-based CAM in adults, a systematic review was undertaken.

## 2. Methods

### 2.1. Search strategy

Initially, searches contained an extensive number of synonyms for adherence and CAM which resulted in an extremely large number of records. An example can be found in Appendix B.1, along with all the search strategies and results included in Appendices B.2 to B.10. This necessitated the decision to use only the most relevant and common terms to practically conduct the review.

The literature search was then conducted in the default fields, which were all fields or the multipurpose field for the Ovid platform, on the three most common synonyms of 'adherence'. The terms used were variations of 'adherence', 'compliance' and 'concordance': adher*, comply*, complie*, complia* and concord*. They were combined with "complementary medicine", "complementary therapy", "alternative medicine" and "alternative therapy", and their plural forms: "complementary medicines", "complementary therapies", "alternative medicines" and "alternative therapies". They were the components that formed the officially recognised term 'CAM'. All terms were mapped to equivalent subject headings with the descriptor exploded where controlled vocabulary was available. The selected subject headings were: "Patient Compliance", "Treatment Compliance", "Complementary medicine", "Complementary Therapies", "Alternative Medicine" and "Alternative Therapies". The search was conducted in the following databases: PubMed, Embase, IPA, PsycINFO, CINAHL, BNI, CENTRAL, AMED and OpenGrey on 26/1/2016.

A backward citation search was also conducted so noteworthy articles were not missed.

### 2.2. Inclusion and exclusion criteria

Editorial and letter publication types were excluded before the references were imported into EndNote for convenience. Duplicates were removed. Titles and abstracts were deemed relevant if they described a primary study investigating the adult population, a consultation for provision of treatment, which was considered CAM, and measured adherence. Titles, abstracts or keywords that mentioned attitudes and beliefs were found by searching "attitude" and "belie" in the default field; which is any field; within the reference manager. The inclusion and exclusion criteria were piloted on five articles before being applied on the relevant titles and abstracts and then full texts.

For an article to be included in the review, participants were required to be aged 18 or above at study enrolment seeking treatment for their own condition. A consultation for treatment would need to occur in the study, whereby the CAM practitioner speaks to the patient, collects information from him or her and offers advice. The treatment must be currently termed CAM or listed under the term in databases at the time of the search, which includes fad diets and hypnotism, but not physiotherapy and psychotherapy. Studies investigating non-herbal medicine that is new or for an unlicensed indication, except in mesotherapy, were excluded. Treatment must be taught or provided to patients by a CAM practitioner rather than through a device or media, such as DVD. Directions given to each patient allocated to receive them should be specific to individuals if in a group setting. Studies needed to report outcomes of treatment adherence rate not as a subjective rating, or drop out rate, along with patient attitudes and beliefs towards CAM for inclusion in the review. This meant measurements of treatment evaluation like satisfaction, acceptability, credibility, well-being as part of quality of life assessments and knowledge only for attitudes and beliefs were not accepted, in addition to illness perceptions and beliefs of receiving treatment or placebo. Studies that measured motivation or appreciation of CAM were included. The study type was restricted to

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