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# Surely you take complementary and alternative medicines?

A substantial proportion of our patients use or consider using complementary and alternative medicines (CAM) and other coping strategies. It is important that we acknowledge this, know something about the subject and are aware of current or potential developments in the field. These remedies might be harmless, beneficial or harmful and their side-effects might alter and confuse clinical presentations. We need to be vigilant of the potential for significant drug interactions between complementary and orthodox treatments. There is a substantial growth in complementary and alternative medical research in the USA, now beginning to follow in the UK. This will hopefully bring useful future progress.

Those of us who graduated in medicine in the past century were often tutored in a world in which it was taken for granted that patients take what they are prescribed, and professors frown upon debate about alternative and unorthodox approaches. In Leicester, medical students are now allocated a week on a range of topic titles that do not flow easily off the tongue, including complementary and alternative medicines (CAM). The General Medical Council has stated that medical students 'must be aware that many patients are interested in and choose to use a range of alternative and complementary therapies. Graduates must be aware of the existence and range of such therapies, why some patients use them, and how these might affect other types of treatment that patients are receiving.' (General Medical Council Education Committee, 2002). In our experience, medical students really do know that about half of all prescriptions are never followed through 'compliantly'; many such students also use a wider range of alternatives for treating stress symptoms than the alcohol on which we and the present generation of youthful medical school deans once relied.

There is a growing foundation of research evidence for complementary and alternative medicine, which is now a registered medical subject heading (MeSH) search term. A growing number would argue that it is no longer correct to state that there is little or no evidence for these medicines, pointing to Prince Charles' Integrated Healthcare Initiative as giving them a push in the right direction (Foundation for Integrated Medicine, 1977). Until very recently, there has been a lack of research infrastructure and a lack of funding; however, 'no evidence' is not acceptable as evidence against. So what should we be doing in psychiatry?

## Psychiatry and complementary and alternative medicines

There are no psychiatric textbooks devoted to complementary and alternative medicine. But for those interested, there is a desktop guide for health professionals published by Harcourt (Ernst *et al*, 2001), which covers diagnostic methods, complementary and alternative therapies, herbal and non-herbal medicines, alternative approaches to generally accepted and defined medical diagnoses, sections devoted to complementary and alternative medicine in different world regions, legal, economic, ethical and safety issues. We found this book informative and soberly written, the section on safety being particularly sensible, and arguably not far from being compulsory reading.

Turning to the scientific literature, there are already a number of excellent systematic reviews ongoing in this field. But we wondered how much there might be in connection with psychiatry, while in no way claiming to attempt to carry out a thorough or systematic review of the field. Our purpose was to highlight the topic and reflect on our own lack of awareness in a poorly-understood area of considerable importance to many of our patients and of others in our society. The existence of 'CAM', the MeSH indexing search term, made our task seemingly easier and also interesting. It provided us with an opportunity to quickly establish links in the literature between clearly psychiatric topics (schizophrenia, depression) and a possible item of complementary and alternative medical literature. It also provided what proved to be an interesting opportunity to view the practical outcome of the systematic use by professional (MeSH) indexers of an operational definition of



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complementary and alternative medicine. One of us (H.R.) also has a long-standing interest in the topic, thus providing a wider perspective on potentially valuable contributors to the field. Other sources we looked at (PubMed, up to February 2002) were the National Health Service (NHS) Centre for Reviews and Dissemination (CRD) and the Cochrane Library.

Our search of 'CAM' and depression or schizophrenia yielded 110 references, of which 55 were linked to the topic of schizophrenia. Three reviews have been completed by the CRD on herbal medicine, acupuncture and homeopathy (Linde *et al*, 2001; *a*, *b*, *c*). With the exception of *Hypericum perforatum* (St John's wort), none of these reviews provide any guidance on the management of psychiatric disorders. It was striking how few articles dealt with the usual and expected CAM headings of herbal remedies and of CAM therapies, such as homeopathy, meditation, acupuncture and hypnotism. The search seemed to provide two important preliminary lessons: the difficulties involved in trying to apply conventional standards of the quality of the evidence base in these areas; the sheer paucity of good quality research and therefore, the implication that there are potential opportunities that are being missed.

Not surprisingly, our search yielded numerous (19) references to St John's wort, which has been the subject of a number of recent articles in major medical journals such as the *Journal of the American Medical Association* and the *BMJ*, hence some hesitation on our part in setting down anything in draft now that could well be redundant by the time it reaches readers. However, at the time of writing, the following appear to be broadly acceptable statements: 'There is evidence that extracts of St John's wort are more effective than placebo for the short-term treatment of mild to moderately severe depressive disorders.' 'The current evidence is inadequate to establish whether St John's wort is as effective as other antidepressants.' 'Further studies comparing St John's wort with standard antidepressants in well-defined groups of patients over longer observations periods, investigating long term side-effects, and comparing different extracts and doses are needed' (Linde & Mulrow, 2003). There have been several randomised controlled studies published since the Cochrane review, which has not yet been updated. The most recent study concluded that St John's wort was not effective for treatment of major depression (Shelton *et al*, 2001).

The *British National Formulary* (BNF, September 2000) entry also reminds us of some of the potential pitfalls: preparations of St John's wort can induce drug-metabolising enzymes, and a number of important interactions with conventional drugs (including the contraceptive pill) have been identified (Ernst, 1999). The problem, as with all non-licensed preparations, is that we know very little about what the hazards are, not to mind the possible advantages. If many of our patients are using alternatives, it is important for us to be knowledgeable about these and yet the required knowledge is not easy to find. There are sources of information on the Internet aimed at both professionals and the public on this topic. The Medicines Control Agency (MCA) have a section on herbal medicines in their website: this includes a herbal safety news section (http://www.mca.gov.uk/ourwork/licensingmeds/herbalmeds/herbalsafety.htm).

In their textbook, Ernst and colleagues point to a number of hazards of which users may be little aware: the presence of contaminants in herbal medicinal products, adulteration (including the use of phenobarbital and corticosteroids in one study of Chinese herbal products) and under-dosing of products. They also point out that in the US, UK and Canada, herbal medicinal products are by and large marketed as food supplements, not subject to rigorous regulation required in the pharmaceutical sector (Ernst *et al*, 2001).

## Perception, behaviour and expectation: our public, our patients

The general public (and therefore our patients) are increasingly interested in mind–body concepts and non-medical solutions to health issues (Lemonick, 2003). A recent article addressed to general psychiatrists (Rampes, 2001) emphasises the importance of awareness of complementary and alternative medicine use in our patients. A National Institutes of Health-funded national household telephone survey conducted in 1997–1998 ($n$=9 585) was used to examine the relationships between the use of complementary and alternative medicine during the past 12 months and indicators of mental disorders in the USA (Unutzer *et al*, 2000). Use of complementary and alternative medicine during the past 12 months was reported by 16.5% of the respondents. Of those respondents, 21.3% met diagnostic criteria for one or more mental disorders, compared with 12.8% of respondents who did not report use of alternative medicine. Individuals with panic disorder and major depression were significantly more likely to use alternative medicine than those without those disorders. Respondents with mental disorders who reported use of alternative medicine were as likely to use conventional mental health services as respondents with mental disorders who did not use alternative medicine. The authors recommended that conventional medical providers should ask their depressed and anxious patients about the use of alternative medicine. They also recommended that practitioners of alternative approaches ask about their patient's use of conventional treatments. Similar community survey findings have been reported from Australia (Jorm *et al*, 2002). Rampes also quotes a smaller study in a US psychiatric out-patient clinic population (Knaudt *et al*, 1999) showing that over half used complementary and alternative medicines, mainly in the form of herbal remedies. Clearly as psychiatrists, we need to be aware of our patients' use of these medicines, their knowledge and expectations of both alternative and orthodox treatments. Those of us dealing with children, people with learning disabilities and elderly patients will also need to be vigilant regarding the approaches taken by carers. Psychiatrists, and particularly adult general psychiatrists, need no reminding of the growing impact on mental health of the use of non-prescribed central nervous



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system active drugs and, yet, an alternative perspective should remind us to ask our patients what they gain in terms of relief from distress through such activity.

The remainder of our search of existing databases lent support to the view that complementary and alternative medicine and long-standing theoretical concepts in psychiatry overlap considerably. Our search on depression and 'CAM' found papers on hypnosis, psycho-oncology, prayer, meditation, on the role of the arts (music, painting) and for example on the effects of imaginal exposure in post-traumatic stress disorder. We were also reminded that our conventional interdisciplinary boundaries may be particularly unhelpful when approaching this subject area. For example, one open treatment study on a heterogeneous population of patients with physical or mental problems describes the effects of offering meditation on a range of outcomes: health-related quality of life, and measures of physical and psychological illness (Reibel *et al*, 2001).

Occasionally, concepts that many of us might regard as orthodox core topics within psychiatry or psychology are termed as complementary or alternative: social relationships and social support (Bullers, 2000); the effect of biofeedback on locus of control in depression (Uhlmann & Froscher, 2001), culture and psychopathology and on social skills training. We even found one theoretical discussion published in *Nature*, and thus at the core of current biomedical and neuropsychiatric thinking, that was 'CAM' indexed, setting out the current case for the brain basis of mental phenomena (Andreasen, 1997). In relation to the topic of schizophrenia, there were a surprising number of papers indexed on cognitive psychology and neuropsychology.

## Potentially promising topics

Western medicine tends to emphasise diagnosis and treatment of disease, as opposed to the early recognition of symptoms at a stage when the largely unresearched potential of prevention and health promotion may have much to offer. It is therefore important to consider how people cope with minor symptoms at a point at which they may still feel in far greater control of such processes. This could include the growing use of techniques to promote well-being such as meditation and yoga, the benefits of which are largely unresearched in relation to milder mental health symptoms.

An important topic that we can only just mention in the context of complementary and alternative medicine is that of placebo. This important medical concept exemplifies the double-edged orientation that doctors may adopt to it: that of promoting harmless benefit and in contrast, that of dismissing the pursuit of the irrational. Consultation time in complementary and alternative medicine may be longer than in routine primary care consultations in the NHS in Great Britain, and may thus provide a greater opportunity for support and demonstrating respect. Initial consultation time is also longer in psychiatry allowing more time for supportive interaction. However, the potentially powerful effect of physical contact and touch, understandably, is eschewed in psychiatry: a technique that is fundamental to the popular alternative therapies of acupuncture, massage, shiatsu and reiki. Thus we may underestimate the non-specific effects of treatment in doctor–patient interactions. As a clinical profession with the task of achieving health gain, we should perhaps ask how can we better harness such potentially beneficial treatment effects ourselves or by working in complementary ways with other complementary and alternative medical practitioners?

Some approaches may straddle the borderline between orthodox medicine and complementary and alternative medicine, one example being the use of melatonin in sleep disturbance in neurological and psychiatric disorders such as depression (Dolberg *et al*, 1998).

## Conclusions

We believe that there are some important lessons to be drawn for psychiatry. Under-diagnosis, under-treatment and low compliance (Wright, 1993) are ubiquitous in primary mental health care and quite possibly also in secondary care. It sometimes seems like a miracle that anyone with a mental disorder consulting a primary health care service manages to complete an evidence-based course of orthodox and potentially effective treatment. Unless we understand and acknowledge the power of ignorance, shame and stigma, the barriers to effective mental health care will continue to be too high for too many physicians and their patients to overcome. Therefore, it makes sense to be willing and prepared to work in a partnership with patients' beliefs and preferences – provided their actions are safe. Ask your patients how they treat their own illnesses and specifically ask what alternative or complementary remedies they are using or have tried. If you do not, you may miss potentially harmful interactions between orthodox pharmacological treatments and non-orthodox medicines, herbs and other substances. If you do, you may make a contract that leads to a more accurate diagnosis and a successful outcome, whether with a safe alternative or indeed a relatively safe orthodox treatment.

## Recommendations

1 Be patient – for many older medical colleagues, psychotherapy and counselling is still viewed as quackery – your orthodox treatments may be someone else's alternative treatments. Your medical students and recently recruited senior house officers may also be a step ahead of you on this.
2 CAM has been under-researched and probably under-resourced, so it is hardly surprising that with the possible exception of *Hypericum*, to date there does not seem to be strong evidence (i.e. replicated randomised controlled trial based) favouring any other CAM intervention such as acupuncture, homeopathy, other herbal remedy, spiritual healing/prayer, meditation, etc. in a clearly defined disorder in a well-described population.



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*Hypericum* seems to be efficacious in mild to moderate depressive symptoms, but not in major depression. There are substantial problems with interactions between *Hypericum* and many other drugs (see MCA and BNF). Of course, the recommendations set out here are tentative and should be evaluated objectively.

3 It is a miracle that anyone with a mental disorder ever completes an evidence-based course of orthodox treatment because of under-diagnosis, under-treatment and low compliance. Unless we understand and acknowledge the power of stigma, the barriers will continue to be too high for too many people.

4 Ask your patients how they treat their own illnesses and specifically ask what alternative remedies they are using or have tried. Create an expectation that we realise that coping with mental illness is not just about stress management and talking it through with someone: we know people try off-the-shelf remedies. This may well pave the way to a more viable therapeutic contract, in which what is agreed to is what happens between follow-up consultations. Indeed, if you do not you may misunderstand the significance of certain hard-to-explain symptoms and you may miss potentially harmful drug interactions.

5 Be willing and prepared to work with patients' beliefs and preferences while establishing and being frank when you feel their actions may be unsafe, which may well be rarely so. Patients who seek out alternative remedies may well be far more amenable to more effective (and in that sense safer) psychopharmacological interventions. By being open and accepting towards the use of safe alternatives, the longer-term objectives of therapy may be easier to achieve, such as establishing compliance with the use of an effective psychotropic agent, or fuller and more consistent engagement in an effective structured psychological intervention.

## Declaration of interest

Some observations expressed here [*sic*] were included in a presentation to the Annual Meeting of the Royal College of Psychiatrists, Edinburgh, July 2003.

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