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
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 manage-
ment 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.’ ‘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 inter-
actions with conventional drugs (including the contra-
ceptive 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/
licensingsmeds/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 disor-
ders 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 prac-
titioners of alternative approaches ask about their
patient’s use of conventional treatments. Similar commu-
ity 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 (Knauert
et al, 1999) showing that over half used complementary and
alternative medicines, mainly in the form of herbal reme-
dies. Clearly as psychiatrists, we need to be aware of our
patients’ use of these medicines, their knowledge and
expectations of both alternative and orthodox treat-
ments. 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
In relation to the topic of schizophrenia, there were a number of papers that were 'CAM' indexed, setting out the current case for the potential of prevention and health promotion may have much to offer. It is therefore important to consider how 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.

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.
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, undertreatment 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
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