

GUEST EDITORIAL

Alternative Therapies and Symptom Management

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Symptoms, from the perspective of the health professional, indicate that something is amiss. This "something" could simply be our body telling us that we require rest, nourishment, or fluid, or it could be a complex response from an etiology of known or unknown origin. As health professionals, we are compelled to investigate the nature of symptoms when they are presented to us, verbally or non-verbally, by those for whom we provide care. Based on our assessment, we can generate hypotheses that can be further investigated to determine the cause of the symptom. When it is of an objective nature, such as fever, we are able to measure it accurately in well-established measurement units (i.e., degrees) that correctly indicate the degree of severity. The severity of the symptom provides further information that will aid in the search for the cause of the underlying dilemma. However, when the symptom is of a subjective nature, such as pain, fear, or anxiety, accurate measurement can be a problem, particularly if the individual is unable or unwilling to provide an accurate verbal description. Because these subjective symptoms are all somewhat familiar, our assessment of them frequently is laden with personal opinions, beliefs, attitudes, and expectations about what will effectively eliminate them. Unfortunately we often bring these value-laden biases into new patient situations, thus influencing what we hear from and/or see in those we are caring for.

While we are attempting to assess symptoms in an accurate manner, we are also trying to "manage" the symptom using the safest and most efficacious intervention we can. But what do we really mean by "manage"? Ideally, we manage a symptom by instituting an intervention that will eliminate it and prevent its return, or, if this is not possible, by striving to provide a therapy that will relieve, reduce, ameliorate, or simply make whatever is amiss better. Based on this ideology, symptom management should be broad in scope, encompass all types of safe and effective therapies, and be based on the best and most current research evidence available. In reality, however, we frequently

settle for less than the ideal and resort to those interventions, strategies, or therapies that are familiar to us and appear to have worked in practice but may not have been rigorously researched. Unfortunately, as many therapies, particularly alternative therapies, do not have a firm base of evidence, we often indulge our biases in the selection of a particular therapy for symptom management.

The focus of this issue of the Journal is alternative therapies and symptom management. This focus may require some elaboration, so that our message is clear.

First, alternative therapy in this instance means *alternative to traditional management*. For example, in dealing with pain, the type of management traditionally employed involves the use of pharmacologic agents. Alternative therapies, therefore, are those that are not pharmacologic in nature, such as physical therapies (e.g., heat, ice, positioning), behavioural therapies (e.g., relaxation, sucking, music), and cognitive therapies (e.g., guided imagery, thought stopping, preoperative education). The past decade has witnessed increased public awareness and use of alternative therapies for symptom management, the most popular of which include acupuncture, reflexology, aromatherapy, massage therapy, music therapy, spiritual healing, and self-help approaches. Alternative therapies reportedly are used by 20% to 50% of persons in all sociodemographic groups in industrialized countries, with an estimated \$14 billion being spent on such therapies in the United States alone (Margo, 1999). A large number of publications are devoted to alternative therapies, medical and nursing schools are offering courses in them, and funding agencies are making funds available for the systematic investigation of their effects.

Second, alternative therapies and symptom management do not necessarily go hand in hand. We are not inferring that alternative therapies are the optimal, only, or most appropriate method of symptom management. Rather, we are striving to broaden the repertoire of strategies that health professionals consider when faced with the challenge of managing a particular symptom. All too often we rely on traditional therapies exclusively when alternative therapies may be effective either used alone or used in combination with traditional therapies to manage symptoms.

Third, the need for research evidence on which to base practice is the same for traditional and alternative therapies. Nursing research is needed to demonstrate a rational basis for patient care (Hinshaw, 1989). Therefore, nurses need to work within a framework of scientific verification, as opposed to a traditional base, that emphasizes intellectual over

practical knowledge (DiCenso, Cullum, & Ciliska, 1998). Alternative therapies require the same rigorous research as traditional therapies to ensure their safety and effectiveness and to understand their underlying mechanisms of action. This mandate has not historically been adhered to by health researchers and clinicians. Frequently the basis for implementation has been at best anecdotal evidence or the belief that a therapy is either inert or harmless. Therefore, therapies are frequently implemented without adequate evaluation of their effectiveness or safety.

Based on the need for rigorous research and further exploration of research and theoretical issues surrounding symptom management and alternative therapies, we have gathered five unique papers in this issue of *CJNR*. Three of these are research studies that report on the effectiveness of alternative therapies for symptom management in individuals ranging in age from neonates to the elderly. The Discourse addresses the important issue of correctly identifying and labelling the type of management implemented in relation to pain. The research methodology paper focuses on a particularly contentious underlying mechanism, placebo, and the research and theoretical implications for symptom management.

One of the studies focuses on neonatal stress and pain. This age group is particularly challenging for professional and parental caregivers, as we are denied the benefit of subjective report for determining both the severity of the symptom and the effectiveness of the therapy. Butt and Kisilevsky focus on the more global symptom of stress, using multiple physiologic and behavioural response indicators. They target heel lance for blood sampling, the most common and frequent procedure facing the preterm infant in the neonatal intensive care unit (NICU). The authors suggest that the challenge for the clinical researcher is to identify methods of modulating stress during necessary procedures, reducing the potentially negative influence on the preterm infant. They address the effect of a music intervention in reducing the stress associated with heel lance in preterm infants. They use music, which has the potential for use with all premature infants, to mask aversive environmental stimuli in the NICU or to soothe the infant by modulating behavioural state. The results of this study demonstrate that music modulates both physiological and behavioural responses in preterm infants of a particular gestational age following stress-provoking heel lance. These findings may have important implications for the care of preterm infants both in reducing the negative effects of stressful procedures and in promoting the conservation of energy for use in

development. They also add to a body of research evidence on stress reduction during a painful procedure, which is particularly sparse.

The other two research papers focus on the adult and, more specifically, the elderly adult. Watt-Watson, Stevens, Costello, Katz, and Reid were intrigued by the persistent issue of inadequate provision of analgesia for moderate to severe pain after coronary artery bypass graft (CABG) surgery. This study is particularly relevant because cardiovascular diseases are the major cause of death, disability, and illness in Canada and thus have a significant impact on our health-care system. Its purpose was to evaluate a preadmission education booklet with patients undergoing their first uncomplicated CABG. The positive effect of general preoperative patient education on postoperative outcomes has been clearly documented although the impact of perioperative cardiac education has been only minimally examined. A randomized controlled trial (RCT) was undertaken and eligible patients were randomly assigned to receive either a generic hospital booklet and video (control), the control intervention plus a pain booklet, or the control intervention plus a pain booklet and personal interview. Outcomes, including pain, analgesic administration, interference with activities, concerns about asking for help and taking analgesia, and patient satisfaction, were evaluated repeatedly following surgery. Results indicate that analgesic administration was inadequate for all groups despite unrelieved pain. However, patients receiving the interventions received significantly more analgesia than the control group and had fewer concerns about asking for help and taking analgesia. The authors conclude that the problem of post-surgical patients experiencing moderate to severe pain and receiving inadequate analgesia persists. However, changes were evident in the groups who received the interventions. This study clearly emphasizes the need for additional research in the area of post-operative pain management using alternative as well as traditional therapies.

The third study, by Wishart, Macerollo, Loney, King, Beaumont, Browne, and Roberts, evaluated a visiting / walking program for "at risk" elderly persons experiencing cognitive impairments while living at home. This Special Steps Program was designed to enhance quality of life for this group while decreasing the caregiving burden and enhancing quality of life for the caregiver by providing respite. In this RCT, all eligible clients were randomized to receive a volunteer Special Steps visitor as soon as possible (experimental group) or after 6 weeks (control). Outcomes, including patient and caregiver satisfaction, caregiver burden, health expenditures, and quality of life, were evaluated. The experimental group perceived less caregiver burden than the

control group. This study provides the first evidence to support the benefit of a walking program offered by volunteers in the home setting.

Overall, these three studies provide examples of the evaluation of a variety of alternative therapies for symptom management across the life span.

The Discourse in this issue of the Journal addresses the issue of how to describe pain-alleviating interventions that do not involve administration of a drug. Franck eloquently argues that there are extremely important reasons for "saying what we mean and meaning what we say" when we refer to these management interventions. Correct labelling of pain treatments ensures that the symptom is given the importance it deserves by those most competent to assess and manage it. Clear labelling also enhances our understanding of the underlying mechanisms of an intervention, thus minimizing the incorrect application of terms like "placebo." Franck states that we should also be more cognizant of the implied defeatism in such terms as "alleviating," "ameliorating," and "relieving" pain, as they suggest incomplete resolution of the problem. She challenges us to more positively say that we are treating to achieve pain prevention or elimination. Franck concludes by suggesting that if we do not resolve the semantic dilemma regarding pain and interventions to treat pain now, we can be guaranteed that the issue will surface again in the future. She invites discussion and the opportunity for interactive problem-solving around this issue.

Finally, in the methodologic section, Sidani and Stevens suggest that despite wide interest in alternative therapies and the accumulating empirical evidence supporting their effectiveness, some scholars view these therapies with scepticism. They tend to consider them as placebos. In this context, placebo refers to treatments, whether physiological, psychological, or psychophysiological, that are administered for their non-specific, psychological effects, to please or satisfy patients. The arguments for or against viewing alternative therapies as placebos are based on differences in professional paradigms and perspectives on what constitutes a placebo, and subsequently in the theory underlying the therapeutic effects of the treatment or intervention being evaluated. Thus what one professional considers as placebo another views as therapeutic intervention. Sidani and Stevens clarify two perspectives of placebo: the traditional and the alternative. They review the conceptualizations of placebo within each, and the mechanisms underlying the placebo effects. They also discuss the methodological implications of addressing the placebo effects in intervention evaluation research from

the two perspectives. Addressing these effects is essential to enhance the validity of the study conclusions.

In summary, this issue of the Journal provides a fresh look at some of the research, conceptual, methodologic, and practical issues generated around alternative therapies and symptom management. It has been a great pleasure for me to act as guest editor for this issue and I extend my thanks to the *CJNR* editor, Dr. Laurie Gotlieb, my former teacher and always friend and mentor, for giving me this opportunity. Only by bringing key clinical topics and research and theoretical issues to the forefront will we stimulate nurse researchers and clinicians to extend their intellectual curiosity and improve their practice.

Reference

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