Mental Disorders and Reasons for Using Complementary Therapy

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Objective: To compare patients with and without mental disorders who seek services from a complementary therapy practitioner with regard to quality of life, reasons for seeking complementary therapies, complaints, and physical conditions.

Method: We studied new patients who attended a complementary therapy clinic offering acupuncture treatment between July 1, 1993, and March 31, 1995. We collected data from a self-administered questionnaire and from a physician-conducted psychiatric assessment.

Results: Of the 826 new patients at the clinic, 578 (70%) presented with a mental disorder. Patients with a mental disorder perceived their quality of life as poorer and reported greater levels of stress than did those without a mental disorder. However, the groups did not differ in their self-reported reasons for seeking complementary therapies, in their complaints, or in their physical conditions. Among patients with a mental disorder, the major reasons for choosing complementary therapies were personal preference, interest, or belief in complementary therapies (44.3%) and perceiving complementary therapies as a last resort (30.7%). Most patients with a mental disorder saw a complementary practitioner for musculoskeletal and connective-tissue disorders (44.1%), fatigue (26.6%), and headache (15.2%). The most frequent physical illnesses among patients with a mental disorder were diseases of the musculoskeletal system and connective tissue (42.6%).

Conclusion: Like their counterparts without a mental disorder, individuals with a mental disorder use complementary therapies because of personal beliefs. The wide use of complementary therapies among individuals with a mental disorder may be ascribed to a poor quality of life and high levels of distress.

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Clinical Implications

Psychiatric patients who seek help from a complementary therapy clinic do so most often because they have physical complaints, although feelings of depression, stress, and sleep deprivation also play a role.

The main reason for attending a complementary therapy clinic is patient belief in the value of these therapies.

Limitations

This study was conducted at a complementary therapy clinic with a focus on acupuncture treatment, which may limit generalizability of the study findings to other clinical settings.

Key Words: *mental disorders, comorbidity, complementary therapies, acupuncture, quality of life*

Complementary or alternative medicine (CAM) is widely used, ranging from 9% of the population in the UK to 65% in Germany (1). Over a 12-month period in Canada, 50% of the population used a CAM therapy, and 15% visited a CAM practitioner (2,3). However, the use rate in Canada varies greatly depending on the medical condition, from 81% in cancer patients, to 27% in patients with gastrointestinal problems (4–11).

What motivates people to choose CAM? Several studies have consistently reported that CAM users are likely to be middle-aged women with a higher educational level, higher income, and poorer physical and mental health than nonusers (12–15). The presence of a mental disorder is an important indicator for CAM therapy use in the general population, as well as in subpopulations with physical illnesses. Two national surveys in the US (16,17) found that mental disorders were more common in CAM users than in nonusers. CAM use is particularly common in patients with adjustment disorder, major depression, and anxiety or panic disorders (16–18). In a study of patients with early-stage breast cancer, psychological distress and poor self-perceived quality of life were significant markers of CAM use (19). In patients with gastrointestinal problems, anxiety was associated with CAM use (10). Little is known about why patients with a mental disorder are more likely to seek CAM. In this study, we sampled CAM users to examine differences between individuals with and without a mental disorder with regard to their quality of life, their reasons for seeking CAM, their complaints, and their physical illnesses.

Method

We studied new adult patients (age 18 years and over) at a CAM clinic (the Research Centre for Alternative Medicine [RCAM]) located in Calgary, Alberta. The RCAM is a university-affiliated, physician-run clinic. Patients are either referred by their family physician or self-referred. During the study period, the RCAM provided only acupuncture treatment.

We asked new patients in the period between July 1, 1993, and March 31, 1995, to complete a survey questionnaire that contained items on sociodemographic characteristics, reasons for seeking CAM therapy (up to 3 reasons), the patients' 4 most important complaints, and their past health conditions. We also asked patients to complete a global quality of life instrument (the Faces Scale [20]) that addressed 6 domains: general health, general sense of well-being, quality of life, perception of the amount of stress experienced, ability to relax, and perception of sleep quality. For each domain, patients rated their quality of life by choosing, from among the 7 points represented on the Faces Scale, the facial expression that came closest to their current feelings. A psychiatrist interviewed patients and recorded physical and mental conditions that were present at the time of interview. Mental disorders were coded according to DSM- III-R criteria (21). Physical illnesses and complaints were coded according to ICD-9-CM criteria (22).

We used Fisher's exact test to analyze statistical differences in the demographic characteristics of psychiatric and nonpsychiatric patients. We applied logistic regression when adjusting for age, sex, and occupation. All patients included in this study signed a consent form. The study received ethical approval from the University of Calgary.

Results

During the study period, 1261 new patients attended the clinic, and 826 (66%) completed questionnaires and interviews. A psychiatrist gave 578 (70.0%) of these 826 patients a diagnosis of a mental disorder. Depression was the most frequent diagnosis (48.3%), followed by adjustment disorder (32.0%) and anxiety disorder (7.9%). The prevalence for all other psychiatric disorders was less than 4%.

Table 1 compares the demographic characteristics of patients with and without a mental disorder. The proportion of women was significantly higher among patients with a mental disorder (75.6% vs 66.5%, Fisher's $P < 0.001$). The 2 groups did not differ in age and types of occupation.

Table 1 also presents findings from the quality of life scales (ranging from 1, "best possible quality of life," to 7, "poorest quality of life"). After adjustment for age, sex, and occupation, the mean quality of life scores for all 6 measures were significantly higher, indicating poorer quality of life among patients with a mental disorder than among those without a mental disorder.

Table 2 shows that the 2 patient groups did not differ in their reasons for choosing CAM after adjustment for age, sex, and occupation. The most common reason was personal interest, preference, or belief in CAM therapies (44.3% and 40.3% for patients with and without a mental disorder, respectively; adjusted $P = 0.45$). Perceiving complementary therapies as a treatment of last resort was the second most common reason (30.7% and 32.0% for patients with and without a mental disorder, respectively; adjusted $P = 0.80$). About 15% of patients in both groups chose CAM therapies because they were dissatisfied with conventional medicine or because they wanted to avoid conventional medical treatments.

Both patient groups attending the CAM clinic had the same 3 most common complaints: first, diseases of the musculoskeletal system and connective tissues; second, fatigue; and third, headache. Subsequent complaints differed across the 2 groups. Among patients with a mental disorder, the complaints ranked third to fifth were depression (13.5%),

Table 1 Demographic characteristics and quality-of-life scores of patients at a complementary therapy clinic

	Patients with a mental disorder (*n* = 578)	Patients without a mental disorder (*n* = 248)	*P*- value
Characteristics			
Sex female (%)	437 (75.6)	165 (66.5)	< 0.001
Age (years): mean (SD)	43.1 (12.6)	43.9 (13.1)	0.446
Occupation			
Professional (%)	267 (46.2)	111 (44.8)	
Labourer (%)	131 (22.7)	63 (25.4)	
Unemployed (%)	100 (17.3)	36 (14.5)	
Other (%)	43 (7.4)	13 (5.2)	0.2133
Quality-of-Life Measure[a]: mean (SD)			
Physical health	4.0 (1.7)	3.5 (1.7)	0.002[b]
Well-being	3.7 (1.6)	3.0 (1.5)	< 0.001[b]
Quality of life	3.3 (1.7)	2.6 (1.5)	< 0.001[b]
Amount of stress	4.7 (1.6)	3.8 (1.7)	< 0.001[b]
Ability to relax	4.3 (1.7)	3.3 (1.7)	< 0.001[b]
Sleeping	3.7 (1.9)	3.0 (1.8)	< 0.001[b]

[a]7-point face scales of quality of life, from best = 1 to poorest = 7; value 4 = fair
[b]*P*-values adjusted for sex, age, and occupation.

Table 2 Reasons for seeking complementary therapies among patients at a complementary therapy clinic

Reasons	Patients with a mental disorder *n* (% of 548)[a]	Patients without a mental disorder *n* (% of 231)[b]	*P*-value
Personal preference, interest, or belief in complementary therapies	243 (44.3)	93 (40.3)	0.45
Complementary therapies as treatment of last resort	168 (30.7)	74 (32.0)	0.80
Referral	89 (16.2)	44 (19.0)	0.56
Refferal by health professional	43 (7.9)	25 (10.8)	0.25
Referral by friend or family member	46 (8.4)	21 (9.1)	0.98
Dissatisfaction with conventional medicine	50 (9.1)	21 (9.1)	0.97
Trying to avoid medical treatments	34 (6.2)	16 (6.9)	0.64
Other	60 (10.9)	24 (10.3)	0.73

[a]Excludes 30 patients with missing data.
[b]Excludes 17 patients with missing data.
[a,b] Patients could indicate more than one reason; therefore the percentages do not add up to 100.
[c]Adjusted for age, sex and occupation.

stress (9.7%), and sleep disturbance (8.8%); in the patients without a mental disorder, the complaints ranked third to fifth were digestive symptom (8.1%), disturbed skin sensation (4.4%), and obesity (4.0%).

Physical illnesses in the 2 patient groups were diagnosed by a physician at the CAM clinic. The 2 groups did not differ significantly in their physical illnesses after adjustment for age, sex, and occupation. Diseases of the musculoskeletal system and connective tissues were the most frequently diagnosed physical illnesses in both groups, accounting for 42.6% and 42.3% in the patients with and without a mental disorder, respectively (adjusted $P = 0.89$). The second most common group of physical illness related to diseases of the nervous system and sense organs, accountingd for 15.0% and 17.3% in the patients with and without a mental disorder, respectively (adjusted $P = 0.49$).

Discussion

The study aimed to determine differences and similarities between patients with and without a mental disorder who attended a CAM clinic. The elements studied were quality of life, reasons for seeking complementary therapies, reported complaints, and physician-diagnosed physical illnesses. After adjustment for sociodemographic factors, patients with a mental disorder perceived their

physical health, their general well-being, their quality of life, their ability to relax, and the quality of their sleep as poorer, compared with those without a mental disorder. Patients with a mental disorder also considered themselves to be under more stress than did those without a mental disorder. However, regardless of the presence of a mental disorder, most patients gave the same reasons for choosing care at a complementary therapy clinic, reported similar complaints, and had similar physical illnesses.

Why is CAM more commonly used in patients with mental disorders? Astin summarized 3 possible reasons: 1) patients are dissatisfied with conventional treatment, 2) patients want to have control over their health care decision, and 3) patients see that CAM is congruent with their philosophical values and beliefs (18). Astin carried out a survey to test the above hypotheses and found strong support for the philosophical congruence hypothesis but less evidence for the hypothesis regarding patient dissatisfaction with conventional medicine (18). In our study, patients with and without a mental disorder do not appear to differ on self-reported reasons for choosing CAM. The 2 main reasons for both groups were philosophical congruence and perceiving CAM therapies as a treatment of last resort. Fewer than 10% of the sample gave dissatisfaction with conventional medicine as a reason; however, it might be argued that patients who sought CAM as a last resort were also dissatisfied with their conventional medical treatment.

The only significant difference between the 2 study groups was in the measure of patients' self-rated quality of life. Patients with a mental disorder reported poorer physical health and general well-being, more stress, less ability to relax, and more sleep disturbance than did those without a mental disorder. Of these 6 measures, the greatest difference appears in the amount of stress, although both groups reported a great amount of stress. Our findings are congruent with a recent report showing that women with early-stage breast cancer are more likely to turn to CAM when they experience psychological symptoms or distress (19). This suggests that a poorer quality of life and higher levels of stress in the patients with a mental disorder may prompt these patients to use CAM.

Most patients with a mental disorder sought CAM treatment for somatic problems rather than for their mental and emotional symptoms. Musculoskeletal and connective tissue disorders were the most common complaint. This may be related to the fact that the principal therapy provided at the CAM clinic (acupuncture) may have attracted patients seeking pain relief (23). Another possible explanation is that physical illnesses are frequently comorbid with mental disorders, which can be secondary to general medical conditions (24–27).

The study population included a large proportion of patients with mental disorders, consistent with 2 US surveys (16,17) showing higher rates of mental disorders among CAM users, compared with nonusers. However, mental disorder rates cannot be directly compared, because the studies assessed mental conditions differently, reviewed different CAM therapies, and had different population sources. It should be noted that the study clinic has a reputation for treating mental disorders.

Generalizability of our findings may be limited because the study population comprised patients from a single complementary therapy clinic that only provided acupuncture. The physical illnesses and complaints found in our study population may differ from those at clinics offering other complementary therapies.

Another limitation relates to the way psychiatric diagnoses were established in our study: a senior psychiatrist interviewed and assessed all patients and made psychiatric diagnoses according to DSM-III-R criteria (21). Compared with instruments used for psychiatric screening and diagnosing, the DSM-III-R provides broadly defined diagnostic criteria that allow for some variability in assigning a specific diagnosis. However, we did not group patients by specific diagnosis; instead, we classified patients into those with mental disorder and those without. This broad classification of presence and absence of mental disorder decreased the likelihood of misclassifying patients.

Like their counterparts without a mental disorder, individuals with a mental disorder use complementary therapies according to personal beliefs. The wide use of complementary therapies among individuals with a mental disorder may be ascribed to a poor quality of life and high levels of distress.

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