Complementary Therapies in Dementia Care: Which Therapies are Used in South Australian Nursing Homes?

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Abstract

International research has shown that the use of complementary therapies, also referred to as alternative and/or unconventional therapies, is widespread. However, there is little in the scientific literature about the use of complementary therapies in the treatment regime of people with dementia. Dementia and complementary therapies are defined; and the findings from a questionnaire distributed to South Australian High Care Residential Facilities (formerly called Nursing Homes) in 2002 are discussed.

Dementia

...every day a little bit... has gone forever (Freeth 1994, p. 26).

Dementia is a degenerative condition that impairs the physical and mental functioning of the brain resulting in “multiple cognitive deficits” (American Psychiatric Association 2000, p. 147 (DSM-IV-TR)). The term dementia is an umbrella term covering a range of conditions variously described as including Alzheimer’s disease, Down syndrome, Huntington’s disease, vascular dementia, alcohol related dementia, the AIDS Dementia Complex (Freeth 1994), fronto temporal dementia [frontal lobe dementia], drug related dementia, Lewy body disease (Geriaction, no author named, 2001), Parkinson’s disease, dementia due to head trauma, Pick’s disease, Creutzfeldt-Jakob disease and dementia due to multiple aetiologies (DSM-IV-TR). A 1994 study of 123 dementia cases in Australia reported that Alzheimer’s disease accounted for 49.5%, Huntington’s disease 22.3%, vascular dementia 6.8%, Pick’s disease 4.9%, alcohol 4.9%, Creutzfeldt-Jakob disease 1.0%, Parkinson’s disease 1.0%, other causes 4.9%, and in 4.9% of the cases the cause of the dementia was not known (Freeth 1994).

In 1998, it was estimated that dementia affected 1 in 4 Australians aged 85 years and over, 1 in 9 from 80 to 84 and 1 in 15 from 65 to 80, while there may have been as many as 2,000 under the age of 65 years with dementia. It is the fourth largest killer in Australia after heart, cancer and respiratory diseases, and the rate is expected to increase by 254% from 1995 to 2041 due to the general ageing of the population (Alzheimer’s Disease and Related Disorders Association of NSW 2001). Although normally associated with old age, there is an increasing frequency of Early Onset Dementia in people under the age of 65 years. Dementia has been diagnosed in people in their 30’s (Alzheimer’s Association Victoria, no date, online) and the DSM-IV-TR suggests that a diagnosis of dementia is possible in children as young as 4 to 6 years of age, when it is usually associated with head trauma or brain tumour, but that it is uncommon in children and adolescents.

For a formal diagnosis of dementia to be made, there must be an impairment of memory coexisting with at least one of the following conditions: aphasis (a deterioration of language functioning); apraxia (an impairment of motor functioning); agnosia (a failure to recognise or identify objects); or a disturbance in executive functioning (an impairment of abstract thinking and planning) (DSM-IV-TR).
While there are published standardised diagnostic tools available, the DSM-IV-TR emphasises that the degree of impairment may vary according to the social setting. Some of the assessments may be culturally inappropriate, and the individual’s educational background must be considered when making a diagnosis.

Although certain of the dementias such as those caused by substance abuse and cerebrovascular disease may be preventable (Alzheimer’s Disease and Related Disorders Association of NSW 2001), there is no known cure for degenerative dementias such as Alzheimer’s disease (Collins 2001; Jorm 2002; Rowe & Alfred 1999).

In addition to the problems caused for the individual with dementia as they lose the ability to function ‘normally’, the onset of dementia causes significant problems for caregivers. Individual caregivers have described anger, depression, despair, frayed temper, frustration, grief, guilt, heartache, loss of contact with friends and relatives, loss of mutual sharing, loss of physical intimacy, remorse, sadness, self-reproach, and sorrow (Collins 2001). The children of the person with dementia, particularly in cases of early onset dementia, may react so adversely to the increasing debility of their parent that they become a problem both at home and school with a resulting severe and long-lasting detriment to their education (Freeth 1994).

Complementary Therapies

In the scientific literature, terms such as ‘complementary’, ‘alternative’, and ‘unconventional’ are often used synonymously. However these terms do have specific meanings and for the purpose of this paper the following definitions will be used:

- ‘Complementary’ therapies: To describe therapies which are used to complement traditional allopathic medicine;
- ‘Alternative’ therapies: To describe therapies which are used in place of traditional allopathic medicine;
- ‘Unconventional’ therapies: To describe those therapies which are not normally taught in medical schools.

The work of Eisenberg et al (1993) and Eisenberg et al (1998) indicates that the list of these therapies changes over time as schools of medicine move to incorporate many of them in their teaching.

Furthermore, the terms ‘therapy’ and ‘medicine’ are often used synonymously in the scientific literature. The concept of ‘therapy’ as distinguished from ingested ‘medicine’ will be used in this paper.

While research has shown that people from all socioeconomic backgrounds are increasingly turning to complementary therapies (Eisenberg et al 1993 & 1998; Sherwood 2000), there is little in the scientific literature about the use of complementary therapies in the management of dementia.

2002 Survey of South Australian High Care Residential Facilities

Introduction

Having recognized the paucity of published research into the use of complementary therapies in the management of dementia, the decision was made to conduct a survey of
complementary therapy use in South Australian High Care Residential Facilities (formerly Nursing Homes). The author designed a questionnaire to ascertain:

- the specific use of complementary therapies;
- staff and facility attitude to the use of complementary therapies;
- the perceived efficacy of these therapies;
- funding and staffing considerations;
- the prevalence of dementia in the facilities;
- the type of behaviours exhibited by residents with dementia
- pharmacological interventions

used in residential in South Australia High Care Residential Facilities. The Social and Behavioural Research Ethics Committee of the Flinders University of South Australia approved the questionnaire on the 17th July 2002.

During August 2002, the questionnaire was posted to the 162 South Australian metropolitan and country High Care Residential Facilities as identified by the Seniors Information Service on the 2nd October 2001. Recipients were requested to return the questionnaires by the 30th September 2002.

Up to and including the 1st October 2002, a total of 91 questionnaires (56.2%) had been returned. Of these:

- 6 were blank;
- 1 was returned to the sender by Australia Post;
- 1 was returned with a note indicating that the facility had closed;
- 1 facility had low care accommodation only;
- 1 facility did not have any residents with dementia; and
- 81 questionnaires were available for analysis.

A total of 117 individuals including: 55 Directors of Nursing, 31 Registered Nurses, 15 Diversional Therapists, nine Clinical Nurses (including CNCs), three Care Managers, two Enrolled Nurses, one Patient Care Attendant, and one Manager: Residential Aged Care assisted in the compilation of the questionnaires. As can be seen from Table 1, the response to the questionnaire was often a joint effort between several staff members.
Resident Profile

From the data analysed, 51.5% of residents had dementia with the youngest ages ranging from 39 to 85 years (mean 66.4). The oldest residents with dementia ranged in age from 86 to 105 years (mean 97.0). Twenty-five facilities (30.8%) reported having residents with early onset dementia. A further six facilities reported that their youngest resident was aged 65 years. In these cases, due to the timeframe for obtaining admission to a nursing home, it can be assumed that the diagnosis of dementia was made before the age of 65).

Table 1: Respondents to Questionnaires by Category (n = 81)

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Nursing only</td>
<td>35</td>
<td>43.2%</td>
</tr>
<tr>
<td>Joint responses</td>
<td>27</td>
<td>33.3%</td>
</tr>
<tr>
<td>Clinical Nurse only</td>
<td>8</td>
<td>9.9%</td>
</tr>
<tr>
<td>Registered Nurse(s) only</td>
<td>7</td>
<td>8.6%</td>
</tr>
<tr>
<td>Care Manager only</td>
<td>2</td>
<td>2.5%</td>
</tr>
<tr>
<td>Diversional Therapist only</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Enrolled Nurse(s) only</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Patient Care Attendant(s) only</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Complementary Therapies

Based on an extensive literature survey and anecdotal evidence gathered through personal conversations with staff and volunteers in high care residential facilities, the author compiled a list of 17 complementary therapies which could possibly be used in the management regime for people with dementia. The list included: aromatherapy (massage); aromatherapy (vaporising); behaviour therapy; chiropractic; Healing Touch; light therapy; massage; meditation; music (instrumental); music (recorded); music (voice); prayer; reflexology; Reiki; tai chi; Therapeutic Touch (Krieger/Kunz method); and ThreePhase Therapy. Respondents were asked to state which therapies from this list (arranged alphabetically) were used in their facility, and to indicate the use of complementary therapies not included in the list supplied.

All 81 facilities reported that they believed in, and used at least two complementary therapies. Facilities reported a total of 33 different complementary therapies as detailed in Table 2.
Table 2: Complementary Therapy use in Residential High Care Facilities in South Australia (n = 81)

<table>
<thead>
<tr>
<th>Therapies Reported by the Facilities</th>
<th>Number</th>
<th>Percentage</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aromatherapy (vaporising)</td>
<td>72</td>
<td>88.9%</td>
<td>82.1%, 95.7%</td>
</tr>
<tr>
<td>Music (recorded)</td>
<td>65</td>
<td>80.2%</td>
<td>71.5%, 88.9%</td>
</tr>
<tr>
<td>Aromatherapy (massage)</td>
<td>64</td>
<td>79.0%</td>
<td>70.1%, 87.9%</td>
</tr>
<tr>
<td>Massage</td>
<td>57</td>
<td>70.4%</td>
<td>60.4%, 80.3%</td>
</tr>
<tr>
<td>Prayer</td>
<td>50</td>
<td>61.7%</td>
<td>51.1%, 72.3%</td>
</tr>
<tr>
<td>Music (instrumental)</td>
<td>49</td>
<td>60.5%</td>
<td>49.8%, 71.1%</td>
</tr>
<tr>
<td>Music (voice)</td>
<td>38</td>
<td>46.9%</td>
<td>36.0%, 57.8%</td>
</tr>
<tr>
<td>Behaviour Therapy</td>
<td>31</td>
<td>38.3%</td>
<td>27.7%, 48.9%</td>
</tr>
<tr>
<td>Healing Touch</td>
<td>17</td>
<td>21.0%</td>
<td>12.1%, 29.9%</td>
</tr>
<tr>
<td>Reiki</td>
<td>15</td>
<td>18.5%</td>
<td>10.0%, 27.0%</td>
</tr>
<tr>
<td>Therapeutic Touch (Krieger/Kunz method)</td>
<td>13</td>
<td>16.0%</td>
<td>8.0%, 24.0%</td>
</tr>
<tr>
<td>Tai Chi</td>
<td>12</td>
<td>14.8%</td>
<td>7.1%, 22.5%</td>
</tr>
<tr>
<td>Light Therapy</td>
<td>11</td>
<td>13.6%</td>
<td>6.1%, 21.1%</td>
</tr>
<tr>
<td>Meditation</td>
<td>6</td>
<td>7.4%</td>
<td>1.7%, 13.1%</td>
</tr>
<tr>
<td>Reflexology</td>
<td>6</td>
<td>7.4%</td>
<td>1.7%, 13.1%</td>
</tr>
<tr>
<td>Reminiscence Therapy</td>
<td>9</td>
<td>7.3%</td>
<td>1.6%, 13.0%</td>
</tr>
<tr>
<td>Pet Therapy</td>
<td>8</td>
<td>6.5%</td>
<td>1.1%, 11.9%</td>
</tr>
<tr>
<td>Snoezelen</td>
<td>8</td>
<td>6.5%</td>
<td>1.1%, 11.9%</td>
</tr>
<tr>
<td>Validation Therapy</td>
<td>3</td>
<td>3.7%</td>
<td>0.0%, 7.8%</td>
</tr>
<tr>
<td>Cooking</td>
<td>3</td>
<td>3.7%</td>
<td>0.0%, 7.8%</td>
</tr>
<tr>
<td>1:1 activities</td>
<td>3</td>
<td>3.7%</td>
<td>0.0%, 7.8%</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>2</td>
<td>2.5%</td>
<td>0.0%, 5.9%</td>
</tr>
<tr>
<td>Doll Therapy</td>
<td>2</td>
<td>2.5%</td>
<td>0.0%, 5.9%</td>
</tr>
<tr>
<td>Gardening</td>
<td>2</td>
<td>2.5%</td>
<td>0.0%, 5.9%</td>
</tr>
<tr>
<td>Red Cross (hand &amp; nails)</td>
<td>2</td>
<td>2.5%</td>
<td>0.0%, 5.9%</td>
</tr>
<tr>
<td>Church Services</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
<tr>
<td>Craft</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
<tr>
<td>Hairdresser</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
<tr>
<td>Hot Towel</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
<tr>
<td>Laughter</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
<tr>
<td>Multi-sensory</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
<tr>
<td>ThreePhase Therapy</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
<tr>
<td>Visits (outings)</td>
<td>1</td>
<td>1.2%</td>
<td>0.0%, 3.6%</td>
</tr>
</tbody>
</table>

**Aromatherapy**

Aromatherapy is the most used complementary therapy with 97.5% of the facilities reporting the use of aromatherapy in the form of: vaporising – 88.9%; and aromatherapy massage – 79.0%.

**Touch**

The second most frequently used complementary therapy used is touch with 95.1% of facilities reporting its use in the form of: aromatherapy massage – 79.0%; massage – 70.4%; Healing Touch – 21.0%; Reiki – 18.5%; Reflexology – 7.4%; and Chiropractic – 2.5%.
Music

While it can be reasonably expected that individual tastes in music will vary greatly according to the resident’s age and background, music is commonly used as a complementary therapy with 87.6% of facilities reporting its use in the form of: recorded music – 80.2%; instrumental music – 60.5%; and voice – 46.9%. The fact that tastes in music will vary considerably is highlighted by the comment from one facility that a 59-year-old resident “actually enjoys ‘Beatles’ music!”

Energy

With 87.6% of facilities reporting the use of energy therapies in the form of: Healing Touch – 21.0%; Reiki – 18.5%; and Therapeutic Touch – 16.0%, energy therapies are the fourth most commonly used form of complementary therapy.

Other Therapies

As can be seen from Table 2, other forms of complementary therapies being used include: prayer – 61.7%; tai chi – 14.8%; light therapy – 13.6%; meditation – 7.4%; reminiscence – 7.3%; pets – 6.5%; Snoezelen – 6.5%; validation – 3.7%; cooking – 3.7%; unspecified 1:1 activities – 3.7%; dolls – 2.5%; Red Cross (hand and nails) – 2.5%; church services – 1.2%; craft activities – 1.2%; gardening; hairdresser – 1.2%; hot towel – 1.2%; laughter – 1.2%; maps; multi-sensory – 1.2%; ThreePhase Therapy – 1.2%; and visits (outings) – 1.2%.

It could be conjectured that many more of the facilities use a wide range of these therapies but did not report them as such as they are considered to be simply a part of normal routine.

Positive Effects

The positive effects of complementary therapies reported by facilities included: calming, soothing and settling; improved behaviour management; enhanced quality of life; 1:1 interaction; stimulation of interest and senses; and reduced need for medication (see Table 3).

Table 3: Why Complementary Therapies are used in the Management of Dementia (n = 68)

<table>
<thead>
<tr>
<th>Reason for Using Complementary Therapies</th>
<th>Number</th>
<th>Percentage</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calming, soothing and settling</td>
<td>42</td>
<td>61.8%</td>
<td>50.2%, 73.3%</td>
</tr>
<tr>
<td>Improved behaviour management</td>
<td>15</td>
<td>22.0%</td>
<td>12.2%, 31.8%</td>
</tr>
<tr>
<td>Enhanced quality of life</td>
<td>14</td>
<td>20.6%</td>
<td>11.0%, 30.2%</td>
</tr>
<tr>
<td>1:1 interaction</td>
<td>9</td>
<td>13.2%</td>
<td>5.2%, 21.2%</td>
</tr>
<tr>
<td>Stimulation of interest and senses</td>
<td>9</td>
<td>13.2%</td>
<td>5.2%, 21.2%</td>
</tr>
<tr>
<td>Reduced need for medication</td>
<td>5</td>
<td>7.4%</td>
<td>1.2%, 13.6%</td>
</tr>
</tbody>
</table>

Comments regarding the positive benefits to be gained from complementary therapies were varied and provide a valuable insight into why these therapies are used in the care of people with dementia. The comments included:
“[most] Residents enjoy music therapy”;
“gives resident feeling of being valued ... provides outlet for anger, grieving, stress. Provides spiritual comfort.”;
“1:1 and group human interaction [is] what life is all about”;
“1:1 contact between residents and staff”;
“calming and soothing effect”;
“create pleasant, comfortable environment”;
“creating a home-like calm environment”;
“decrease wandering at night”;
“divert their attention and provide relaxation when restless and agitated”;
“divert their attention”;
“enhance enjoyment now”;
“enhance the lives of those with dementia in many ways”;
“enhances holistic well being”;
“gentle exercises such as tai chi maintain balance and mobility.”;
“gives value to life”;
“group and 1:1 activity reducing inappropriate behaviours and maintains skills”;
“helps staff relate/cope with dementive clients”;
“improve self-esteem”;
“lesses (sic) restless behaviour”;
“make life worth living”;
“Management of behaviours. Increased self-esteem and self-worth”;
“managing adverse behaviours”;
“provide focus, stimulation, relaxation, peaceful environment”;
“reduce reliance on medication”;
“reduces at risk behaviour”;
“relaxation and/or mental stimulation”;
“relaxation”;
“restful sleep, alleviation of pain” and;
“socialisation”. Can we remove the quotation marks in this bulleted list. If so, I will do that for you
Through the comments made by respondents, it was emphasised that complementary therapies have the capacity to engender a positive modification of behavioural problems.

**Therapists**

As can be seen from Table 4, a wide range of staff and volunteers, including diversional therapists, nursing staff, patient care attendants, volunteers, friends and/or family members of residents, as well as visiting specialists provide complementary therapies within the facilities.

<table>
<thead>
<tr>
<th>Table 4: Categories of Persons Providing Complementary Therapies in Residential High Care Facilities (n = 81)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category of Persons Providing Therapy</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Diversional Therapist</td>
</tr>
<tr>
<td>Nurses (Registered or Enrolled)</td>
</tr>
<tr>
<td>Patient Care Attendants</td>
</tr>
<tr>
<td>Volunteers</td>
</tr>
<tr>
<td>Resident’s friends and/or relations</td>
</tr>
<tr>
<td>Visiting specialists</td>
</tr>
<tr>
<td>Other staff</td>
</tr>
</tbody>
</table>

**Exclusion of Complementary Therapies**

Where particular complementary therapies are precluded, this is done because of doubt about the efficacy of the therapy, lack of staff training, religious considerations, time constraints, resident/family choice, and/or difficulty in attracting volunteers or specialist staff.

**Medication**

Seventy-six facilities provided information about the use of medication. Of these, thirty-one (40.8%) reported an average use of more than three medications per resident for dementia and other conditions; 20 (26.3%) reported an average use of three medications; 16 (21.0%) reported an average use of two medications; and nine (11.8%) reported an average use of one medication per resident. No facility reported the non-use of medication.

Given that 51 of these facilities (67.1%) reported that an average of three or more medications are being used in the care of people with dementia, it is advisable to consider the effects of polypharmacy. Lim and Mason (2000) advise that polypharmacy (that is the use of three or more medications of any type) may cause:

- cognitive impairment;
- increased risk of falls;
- an increase in aggressive behaviour.

From this survey, it would appear that Benzodiazepine derivatives (diazepam – 76.6%, flunitrazepam – 5.2%, lorazepam – 24.7%, nitrazepam – 44.6%, oxazepam – 79.2%, and temazepam– 80.5%) are the most frequently used medications for people with dementia. Benzodiazepines, which are only recommended for SHORT TERM use of 2-4 weeks, may induce:
- amnesia;
- ataxia (shaky movements/unsteady gait);
- blurred vision;
- cardio-vascular and respiratory depression;
- coma;
- confusion;
- depressed reflexes;
- extreme drowsiness;
- somnolence

among other conditions (MediMedia 2001 & 2002).

Is There a ‘Perfect’ Complementary Therapy?

There is probably no such thing as a ‘perfect’ complementary therapy (nor a ‘perfect’ therapy of any sort for that matter), as all therapies will have some adverse reaction, however minor, depending on the individual receiving the therapy and how that therapy is applied.

However, by analysing the survey responses, it was possible to draw a number of conclusions about why carers of people with dementia were using individual complementary therapies. It then became apparent to the author that many of the therapies have common features.

Thus, from the analysis of information provided in the questionnaires, it could be argued that a ‘perfect’ complementary therapy could be one which is effective and:

- can be applied when necessary with minimum interruption to routine;
- can be combined with other therapies and/or normal routine;
- can be learnt and then used by the majority of carers;
- can prevent the development of challenging behaviour from becoming a problem;
- can reduce stress levels in both carers and residents while it is being used;
- does not require extensive carer training;
- has little or no adverse reactions;
- is acceptable to residents and carers regardless of their gender and/or religious persuasion;
- is fast acting;
- is inexpensive to implement and maintain;
is simple to administer;

is one which the person with dementia can learn and use for him or herself;

provides maximum subsidiary benefits to both residents and carers;

reduces the workload of carers;

reduces reliance on medication;

is easily learnt and used by children, for as Freeth (1994) reminds us, the children of the person with dementia are also affected.

However, whichever complementary therapies are used, the recipient must have the final say!

The Next Stage of the Research

Before distributing the questionnaires discussed in this paper, the author was aware, through personal discussions, that Reiki was being used in at least three South Australian Residential High Care Facilities. The fact that Reiki is being used in as many as 18.5% (15 – n=81) of facilities responding to the questionnaire was an unexpectedly high incidence.

As there is very little published in the scientific literature about the use and efficacy of Reiki in medical and nursing practice, the next stage of the author’s research will be a series of in-depth interviews with Reiki practitioners caring for people with dementia.
References


