**Introduction**

The UK is home to 60 million people of various ages, cultures, classes and creeds. Whilst almost everyone is registered for health care with the NHS, many individuals consider factors other than mainstream health orthodoxy when seeking to promote their personal wellbeing, or to cope with symptoms of illness. How far then do complementary (practiced alongside conventional) and alternative (practiced instead of conventional) medicines and therapies (CAM) feature in mental health services for older people? What have such therapies to offer? Do they pose benefits, or threats or dangers?

The Alzheimer’s Society\(^1\) comments that a number of herbal remedies show promise in ameliorating symptoms of dementia and indicates benefits from aromatherapy, massage, music, acupuncture, bright light and dietary supplements including antioxidants. It encourages patients to tell their doctors if they are using CAM, and estimates that 30% of people use some sort of CAM at some point in their lives, although the true figure may be much higher.\(^2\) Those who are better educated, married, older and have a religious belief are more likely to be users.\(^3\) Expenditure on CAM is high; one estimate suggested $34 billion dollars annually in the USA.\(^4\)

In contrast to the Alzheimer’s Society, Bandolier is much more sceptical, drawing attention to the lack of what it considers to be high quality evidence for benefits and pointing to potential hazards of several therapies.\(^5\) The Cochrane database of systematic reviews\(^6\) similarly cites the lack of evidence for the effects of several different therapies in dementia including homeopathy, acupuncture, ginkgo biloba and meditation. However, it is sobering that the results for conventional medication and psychological interventions are similarly unimpressive, and the conventional may have substantial side effects.\(^7\) With the limited evidence currently available, should we discount all interventions without
biologically understood mechanisms and statistical evidence for effectiveness, or accept that both conventional and CAM approaches may at least in part have a placebo effect?

Other practices sometimes encountered and deemed effective by individuals and families in various conditions include yoga and various techniques of massage from Eastern disciplines. The research of Elaine Perry and colleagues has done much to bring respect to the use of aromatic oils. A return to an appreciation of spirituality and faith is leading to more collaboration between health care professions and spiritual or faith leaders in the eclectic care of people with dementia and other illnesses. In addition there are anecdotal observed benefits from simple good practices including music, dance, exercise, outings, hair-dos, and pets. Many of these interventions are yet to be studied more formally.

There is good evidence that individualised psychological techniques aimed at the patient’s behaviours, or as education for the carer, are most effective for managing behavioural symptoms in dementia. This individual focus resembles the individualised nature of many types of CAM. Perhaps a one-to-one therapeutic relationship is the root of many of our statistically un-proven yet anecdotally beneficial treatments in dementia, conventional or otherwise.

**Case studies: experiences of CAM in dementia care**

CAM in our experience is not unusual, but can be used for very different reasons, such as it being culturally appropriate, or to emphasise a desperate attempt to treat a dementia.

One example is of a very frail Chinese woman in her late sixties in hospital who could not be encouraged to eat. She was confused and her condition deteriorating after a mitral valve operation. She emphatically refused conventional high calorie liquid food supplements. The family had been reluctant to bring in Chinese medicines for fear that they might interact with her conventional medication. However, they wondered if bird’s nest soup would be a good supplementary food. Bird’s nest soup is a delicacy made from the saliva of certain species of swift. Tradition holds that it provides good nutrition and boosts the immune system. It is extremely expensive and can cost up to $10,000 per kilo. A Traditional Chinese Medicine practitioner suggested less expensive alternatives of jujube dates, ginger, ginseng, tonic herbs, tofu, red beans, red meat, *huang qi* chicken soup or scallop *congee* in chicken stock. The family also asked that acupuncture be considered for her bodily aches and pains.
Her regular medication at this stage included warfarin, but the team was reassured that warfarin was not a contraindication to acupuncture. The team also explored other therapeutic interventions, including learning that acupuncture has been claimed to help depression. This effect may be mediated by endorphins and other neuro-peptides, a highly plausible route to ameliorate depressive symptoms.

Another patient posed a different sort of problem. Of white British ethnicity, he was receiving additional substances from his wife desperate to find something which would restore his intellect. He was found to be consuming almost daily doses of coenzyme Q10, MSM (methylsulphonylmethane), turmeric, choline bitartrate, folic acid, selenium, glucosamine, chondroitin, calcium, omega 3, chromium picolinate, zinc, vitamin B complex and vitamin B12, vitamin D, N acetyl cysteine, ginkgo biloba, ginseng, lecithin, vitamin E, garlic oil and phosphatidyl serine. It is doubtful if the combination had real potential for benefit. Adverse interactions between these substances and conventional prescriptions would be a potential hazard. This combination was almost certainly a drain on family finances and was not well-based in any sort of philosophy, but represented an understandable but cruelly exploited desperate clutching at straws to find something which might just help.

Interviews with users and practitioners give some clues to the reasons why otherwise conservative individuals use fringe therapies. For some the roots lie in belief in philosophies or faith systems. For others the activity is an emotional statement of preference for a degree of personal power, to be self-reliant, self-determining, accepting some of the advice of doctors and other professionals, but reserving a final right to be one’s own person and therapist. The reassurance offered by interpersonal communication with a therapist who is experienced in the condition and has faith in the process may be extremely valuable. Perhaps doctors need to re-explore their own use of the therapeutic relationship in dementia.

**Seeking a holistic model**

Realistic aims are to optimise well-being for patient and carer. Improved well-being may be associated with longer survival, but life-expectancy is not a main consideration. Cure is not achievable so care and therapy in dementia rest within supportive or palliative care paradigms.

Autonomy and choice for the patient, or their delegated representative in accordance with the Mental Capacity Act (2005), is important in clinical practice. If they have capacity to make decisions about CAM we have to
respect them. As practitioners of western medicine, we may feel better if patients use conventional medications about which we feel confident, even if their advantages may be dubious, or associated with risks. However, from the clinical evidence available, we need to listen carefully to our patients who find alternatives beneficial. Acceptance of some alternative but unshared beliefs and interventions may be necessary to foster a therapeutic alliance. Inevitably, sometimes practitioners may find themselves working with CAM therapies whose benefits they doubt. On the other hand, if we are to believe the gold standard Cochrane database, we should doubt many conventional therapies too.

We are not suggesting that doctors initiate unlicensed CAM therapies, but rather see it as imperative that conventional therapists feel confident to enquire what their patients and their families are doing therapeutically otherwise many practices will pass unreported. Information will reveal some patients taking additional approaches to those suggested by the clinic. Lack of compliance with medication, alternatively favouring CAM, may be consequent on side effects or treatment failure but may also represent frank dismissal of the usefulness of a medicine.

In summary, no approach to the management of symptoms in dementia has an exclusive monopoly. The evidence for individual therapeutic and educational approaches in managing behaviours in dementia is compelling and suggests that the therapist-patient-carer dynamic is vital, together with an understanding of what works for that particular individual. CAM is also often very individual focused, although such a model does not help acquire good research evidence for its effectiveness. In reality, evidence of effectiveness is far from adequate in dementia for most CAM, conventional medication and psychological approaches. We have to respect the autonomy and choice for our patients whilst maintaining our therapeutic relationship with them.

Conflicts of interest
None

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