The Use of Complementary and Alternative Medicine (CAM) Among Members of the Canadian Association for Spiritual Care / Association canadienne de soins spirituels (CASC/ASCC)

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Student and professional members of the Canadian Association for Spiritual Care / Association canadienne de soins spirituels (CASC/ASCC) responded to an online survey about their knowledge, training and use of complementary and alternative medicine (CAM). When prayer was included in the final analysis, all respondents used at least one modality for personal care, as well as in their professional practice. When prayer was not included, the vast majority still indicated they used CAM in both capacities. The most frequently used modalities were prayer, meditation, deep breathing exercises, and guided imagery. Significantly more CAM modalities were used for personal care than in professional practice. Female, Anglican and United Church respondents were more likely to use CAM. Those who used CAM for personal care were more inclined to use CAM in their professional practice. There was no correlation between age and use of CAM, or between level of training and use of CAM. Almost one third of respondents reported being "very knowledgeable" about CAM. Limitations of this study and suggestions for further exploration of this topic are discussed.

KEYWORDS: CAM, chaplain, complementary and alternative medicine, prayer, meditation, religion, spiritual care

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INTRODUCTION

Increasingly, spirituality is being recognized in health care literature as a determinant of health, and spiritual care a valuable allied health discipline – integral to a whole-person, patient centered approach. Research is also showing a correlation between patients' spirituality/religiosity and their use of complementary and alternative medicine (CAM), and a growing number of Western medical institutions are integrating CAM modalities into patient care. The researchers, both spiritual care professionals trained in CAM modalities, were interested to find out about the knowledge, training and use of CAM among members of their professional association, the Canadian Association for Spiritual Care/Association canadienne de soins spirituels (CASC/ASCC). This study was designed to overlap with an American study by Jankouwski et al. on CAM usage by religious professionals (including "chaplains, clergy, and pastoral counselors"), and some points of comparison are noted below.

CASC/ASCC is a national, multifaith organization committed to the professional education, certification and support of people involved in spiritual care, pastoral counseling, education and research. Members include students or "interns" in Supervised Pastoral Education (SPE, CASC/ASCC's experiential method of training); professionals; those certified as Specialists (i.e. having completed SPE and a Master's degree, or equivalent, plus additional requirements), and Supervisors (i.e. qualified to teach SPE, having completed Specialist certification plus additional requirements). CASC/ASCC members work in a variety of institutional and community settings such as health care, corrections, education and private practice

Defining the Topic

One of the challenges – and limitations – of this study was defining CAM. There are a number of complexities: for example, among Canada's indigenous and multicultural communities, the understanding and usage of medicines, from traditional to modern, varies. What, in practice, is used as "primary" medicine for some is used as "complementary or alternative" medicine for others.[1] Also, some do not agree with the inclusion of spiritual practices, such as prayer and meditation, in the category of CAM. For the purpose of this survey, the researchers used a definition of CAM from the (American) National Center for Complimentary and Integrative Health, which is consistent with the view of CAM in the Canadian health care system:

> [CAM is] a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional [Western] medicine. 'Complementary medicine' refers to use of CAM together with conventional medicine. 'Alternative medicine' refers to use of CAM in place of conventional medicine. 'Integrative medicine' combines treatments from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness.[1]

[1] According to the World Health Organization (WHO), what is referred to as CAM in some countries may also be called "traditional medicine", i.e. medicine based on the "theories, beliefs and experiences indigenous to different cultures." A 2008 fact sheet reported that, "In some Asian and African countries, 80% of the population depends on traditional medicine for primary health care." In many developed countries, 70% to 80% of the population has used some form of CAM." [1]

Within this definition, a complementary modality may become an alternative modality if used in place of conventional treatment.

Trends in CAM Research and Usage

Due to an increasing research base demonstrating the effectiveness of some CAM modalities to improve quality of life, pain management and patient engagement in their health trajectory, more hospitals are incorporating CAM modalities such as meditation, mindfulness, massage, Tai Chi, and Therapeutic Touch. Similarly, modalities previously viewed as illegitimate by some medical professionals (such as acupuncture) are now being validated as "evidenced based" (Deng 2009).[2] A Canadian study in 2006 indicated 54% of Canadians reported using at least one CAM in the year prior to the survey.[3] Among Ontario breast cancer survivors, over 40% had visited a practitioner like a chiropractor or naturopath, and just over 60% used a product like vitamins/minerals or herbal medicines (Boon, 2000).[4] Across health care, the most commonly used therapies were: massage, prayer, chiropractic care, relaxation techniques, herbal therapies, and acupuncture. Albertans were most likely to use CAM (84%), followed by British Columbians (83%), Quebecers (67%) and those in the Maritime Provinces (63%). The five most common therapies used at least once were chiropractic care (40%), massage (35%), relaxation techniques (20%), prayer (18%), and acupuncture (17%). The study estimated that in 2006, Canadians spent 7.84 billion on CAM, a significant increase of over 2.47 billion compared to 1996. Most used CAM modalities for the prevention of further illness and to support health and vitality. In spite of the growing use and recognition of CAM, 53% of respondents had not discussed their use of CAM modalities with their doctor.

CAM, Spirituality and Spiritual Care

Research indicates a positive correlation between cancer survivor's spiritual well-being and the use of CAM (Crammer, 2010 and Mao 2010).[5, 6] Among physicians, increased spirituality and religiosity coincided with more personal use of CAM, and willingness to integrate CAM into a treatment program (Curlin 2009).[7] In their research, Snyderman and Weil (2002) demonstrated that health care professionals who support the use of complementary alternative therapies are more likely to view patients as "whole persons" or as "spiritual beings."[8]

A 2011 paper comparing individuals who identified themselves as spiritual *but not religious* with individuals who identified as spiritual *and religious* found that the latter group were "43% more likely to use body–mind therapies in general; however, when this category does not contain prayer, meditation, or spiritual healing, they are 44% less likely." Those who identified as religious only were disinclined toward CAM use (Ellison 2005).[9]

In the American study by Jankouwski et al. on CAM usage by religious professionals, the majority "reported that they had experienced using one or more of the CAM therapies over the past year (93%) and that they had experience with using one or more CAM therapies while helping others (85%)."[10] Similar results were found in this study, as will be detailed below.

METHODS

At the time of the study, CASC/ASCC had 272 members. They were invited to participate in a Google online survey, with some questions paralleling those in the Jankouwski et al. study as to their use of CAM, as well as broader questions, which will be outlined below. Seventy-two members (26.47%) completed the survey.

The first section of the survey asked participants to provide demographic information and their level of training with CASC/ASCC. The next section explored their personal and professional use of 40 common CAM modalities (Table 1), including which they used for personal care, professional practice, or both, as well as frequency of and reason for use within the last year. This list was more comprehensive than the one used in the Jankouwski et al. study, which included 21 modalities, and did not include prayer.

Table 1 CAM Practices Listed in the Survey

Acupressure	Flower Essences	Pranic Healing
Acupuncture	Energy Psychology	Progressive Relaxation
Ayurveda	Gem therapy	Qi Gong
Biofeedback	Guided Imagery	Quantum Touch
Brennan Healing Science	Healing Touch	Reflexology
Chakra therapy	Homeopathy	Reiki
Chelation therapy	Hypnosis	Shamanic healing
Chiropracty/Osteopathy	Laying-on-of-Hands	Shiatsu
Colour therapy	Massage	Sound therapy
Craniosacral therapy	Meditation	Tai Chi
Deep breathing exercises	Movement therapies	Therapeutic Touch
Diet-based therapies	Natural products (such as plant products)	Yoga
Eden Energy Medicine	Naturopathy	Other
Emotional Freedom Technique (EFT)	Polarity therapy	N/A

As this survey targeted individuals whom, the researchers assumed, were likely to use prayer as part of their religious/spiritual practice (i.e. more than any other CAM modality listed), prayer was evaluated separately from the other modalities. The survey acknowledged:

> For many, prayer will be a daily practice, but one you might not consider including in the definition of CAM. Nonetheless, alternative medicine researchers and policy makers have classified prayer as a mind-body intervention, and thus, a modality of complementary and alternative medicine. As a result, prayer has been moved to a separate category so as to obtain a more accurate picture of the prevalence of other CAM modalities.

In the remaining sections, participants were asked if they considered themselves knowledgeable about CAM, and what, if any, training they had completed in any CAM. They were also asked about their spiritual/religious practice, outside of their professional practice. At the end of the

survey, participants were invited to leave comments on the use of CAM in spiritual care and counseling. The survey was anonymous. Data was stored in an online, password protected Google Sheets format.

RESULTS

Demographic Characteristics

Of the 72 respondents in this survey, there were significantly more females (61%) than males (39%). The average age of respondents was 54 years (SD=10.3). Regarding their professional or student affiliations, respondents identified as: chaplains (57%); community clergy, seminarians, counselors, and chaplain interns (30%); and others (13%). Eighty-three percent of respondents reported working in health care settings, including hospitals, nursing homes, and hospices. Across all of these categories, 54% of respondents indicated that they were certified as a Specialist, and 12% indicated that they were certified as Supervisors. Respondents reported the following religious affiliations: Buddhist (7%), Catholic (15%), Hindu (1%), Jewish (13%), Muslim (1%), Protestant (49%), Other Christian (10%), and Other Faith or Humanist (5%).

Main Findings

Modalities used

The most commonly used CAM modalities for personal care only were massage (58%), chiropractic/osteopathic (47%), yoga (45%). The most commonly modalities used only for professional practice were guided imagery (8%), laying-on-of-hands (8%), and meditation (4%). When a CAM modality was practiced in both personal and professional capacities, prayer (88%), meditation (50%), deep breathing (43%) were the most common (Table 2. Note: modalities reported by less than 5% of respondents are not shown.)

Table 2 Use of CAM for Personal Care, Professional Practice, and Both.

CAM	Personal Care (%)	Professional Practice (%)	Professional Practice and Personal Care (%)
Massage	58		
Chiropractic/Osteopathic	47		
Yoga	45		
Meditation	33	6	50
Natural products	26		
Deep Breathing	22		43
Naturopathy	22		
Reflexology	21		
Reiki	19		6
Acupressure	18		
Homeopathy	17		
Guided Imagery	15	8	33
Movement Therapy	14		
Craniosacral	12		
Tai Chi	12		

Chakra Therapy	11		
Diet based therapies	11		
Healing Touch	11		14
Qi Gong	10		
Flower Essences	8		
Laying-on-of-hands	8	8	24
Shiatsu	8		
Emotional Freedom Technique	7		
Other	7		6
Progressive relaxation	7		11
Therapeutic touch	7		13
Gem therapy	6		
Prayer	6		88
Sound therapy	6		6
Energy psychology			6

Frequency of Usage

When prayer was included as a CAM modality, all respondents reported using one or more modality in the past year. When prayer was not included, 97% reported using CAM for personal care, and 71% reported using CAM in their professional practice. Two respondents indicated an overlap, though still a distinction, between meditation and prayer.

Table 3 Frequency of CAM Use excluding Prayer

Frequency	Personal Care (%)	Professional Practice (%)
Very often	26	9
Fairly often	35	14
Occasionally	29	34
Rarely	7	14
N/A	3	29

The majority of respondents used CAM for personal care "very often" or "fairly often" (61%). Twenty-three percent used CAM in their professional practice "very often" or "fairly often" (Table 3). Respondents who used CAM more frequently for personal care were also more likely to use CAM in their professional practice.

When asked about the purpose of their personal CAM usage, the majority reported using CAM for improvement of multiple facets of well-being: spiritual and physical health, reducing pain and stress, and anxiety (90%).

CAM Usage and Gender

When analyzed by gender, the data revealed that female respondents used more CAM modalities for personal care than males. This reflects national and global trends of higher use of CAM among females (Frass et al., 2012)[11] (Table 4).

Table 4 Number (SD) of CAM Modalities Used by Gender

Gender (N)	Personal Care	Professional Practice	Both
Female (44)	6.63 (5.51)	0.22 (0.83)	2.79 (2.69)
Male (28)	4.1 (3.4)	0.55 (0.89)	2.11 (2.1)

Also consistent with national and global trends, females use CAM overall more frequently for personal care and in their professional practice than did males (Table 5).

Table 5 Frequency of CAM Use by Gender in Personal Care Compared to Professional Practice

	Gender	N/A	Never	Rarely	Occasionally	Fairly Often	Very Often
Professional Practice	Female	9	5	5	15	7	3
	Male	6	2	5	9	3	3
Personal Care	Female	2	0	3	14	12	13
	Male	2	0	0	9	10	6

CAM Usage and Other Demographics

The Jankouwski et al. study of American religious professionals revealed older participants were more likely to use multiple CAM modalities for personal care. The current study, however, revealed no correlation between age and CAM usage, either for personal care or professional practice. There was also no correlation between the number of years in professional practice and CAM usage.

When analyzing religious affiliation and CAM usage, Roman Catholic, United Church and Mennonite respondents were most likely to use one or more CAM modalities solely for personal use. Roman Catholic, Mennonite and Anglican respondents were least likely to use CAM in professional practice alone, yet Anglican respondents were significantly more likely to use CAM for both personal care and in their professional practice (Table 6).

Table 6 Mean (SD) Number of CAMs by Religion

Religious Affiliation (N)	Personal Care	Professional Practice	Both
Anglican (7)	4.57 (4.03)	0.14 (0.37)	6.42 (2.91)
Baptist (9)	3.33 (2.91)	0.44 (0.72)	3.55 (2)
Roman Catholic (7)	9.28 (7.65	0 (0)	2.71 (2.69)
Mennonite (8)	6.75 (4.2)	0.12 (0.35)	2.87 (3.39)
United Church (14)	7.78 (6.44)	0.35 (0.84)	2.92 (3.12)
Other Christian (22)	4.05 (3.27)	0.47 (1.16)	1.95 (1.88)
Other Faith/Humanist (5)	5.6 (3.28)	0.8 (1.3)	2.4 (1.81)

Training in and Knowledge of CAM

Respondents were asked if they had any training in the CAM modalities they used for personal care or in their professional practice, excluding prayer. Five options were given to indicate their level of training:

- 50% of all respondents either indicated they had "no" training, or they didn't respond
- 11% indicated they had "little" training – i.e. informal training, such as through reading books or watching videos
- 12% indicated "some" – i.e. basic training, such as having taken a formal class or workshop without receiving certification
- 13% indicated "more" i.e. intermediate training, such as multiple workshops or practice group experience, but no certification, and
- 14% indicated "very" – i.e. formal training with certification and membership with the certifying body

No correlation was found between the number of CAM modalities respondents used and their level of training.

Respondents were asked to identify their CASC/ASCC certification status ("none," "Specialist" or "Supervisor"). Supervisors reported less training in CAM than Specialists or those not certified (Table 7).

Table 7 Training in CAM by CASC Certification

Certification	No	Little	Some	More	Very
None	23%	12%	15%	6%	9%
Specialist	43%	0%	13%	17%	23%
Supervisor	33%	44%	0%	22%	0%

Respondents were also asked if they considered themselves knowledgeable about CAM. On a similar 1-5 scale, 7% of all respondents reported "none" (i.e. no knowledge); 13% reported they had "little" knowledge; 20% reported "some" knowledge; 27% reported "more" knowledge; and 33% reported they were "very" knowledgeable (Table 8). Here too, Supervisors reported less knowledge of CAM than Specialists or those not certified.

Table 8 Knowledge of CAM by CASC Certification

Certification	None	Little	Some	More	Very
None	27%	30%	27%	9%	6%
Specialist	20%	27%	30%	23%	10%
Supervisor	33%	44%	22%	0%	0%

As with training, there was no correlation found between respondents' level of reported knowledge and their CAM usage.

DISCUSSION

Among the recommendations made by Jankouwski et al was to examine the relationship between intrinsic and extrinsic religiosity and the propensity of religious professionals to employ CAM practices. The terms "intrinsic" and "extrinsic" religiosity are most commonly known from the work of Gordon W. Allport. However, his conceptualization correlated intrinsic religiosity with religion as an end, and extrinsic religiosity with religion as a means to an end. The two concepts were delineated to address issues such as prejudice, validation, coping styles, narcissism, guilt, fear of death, etc. In Allport's view, extrinsic religiosity correlated with more dysfunctional psychological constructs. In the Jankouwski et al. study, the terms intrinsic and extrinsic religiosity was used instead as central dimensions or expressions self, one not being more or less dysfunctional than the other (as introversion relates to extroversion).

The current study did not explicitly address the concepts of intrinsic or extrinsic religiosity; however these concepts, as understood by Jankouwski et al, might be related to data collected on participants' involvement in religious/spiritual practice outside of their professional practice: i.e. regular or occasional worship, classes and study groups, community service, retreats, prayer, devotions, journaling, meditation, etc. 96% of respondents indicated an active spiritual practice. Those who identified sporadic or occasional attendance in worship, with an emphasis on meditation, reflection or more solitary or small group spiritual practices, were classified as intrinsic. Those indicating regular attendance at worship or community activity, committee work, religious education, wider church activity, etc. were classified as extrinsic. Many respondents seem to fit in both categories. Table 9 organizes the data into these categories, as related to the number of CAM modalities used. Those with an intrinsic religiosity used a slightly higher number of CAM modalities. This analysis could be investigated more thoroughly in future studies.

Table 9 Mean (SD) number of CAM by Religiosity

Religiosity (N)	**# of CAMs**
Intrinsic (17)	11.29 (7.19)
Extrinsic (26)	8.26 (5.45)
Both (26)	7.65 (6.28)
N/A (3)	1.66 (2.08)

Overall, when prayer was included in the analysis, all CASC/ASCC members responding to the survey indicated they use modalities identified as CAM in North American modern health care contexts – both for personal care, and in their professional practice. When prayer was not included, the vast majority still indicated they use CAM. The majority of respondents (61%) used CAM significantly ("very" or "fairly often") for personal care and almost a quarter used CAM significantly in their professional practice. The most commonly used modalities in both capacities were prayer, meditation, deep breathing and guided imagery. Laying-on-of-hands also had notable use. The Jankouwski et al. study did not include prayer, but also found meditation and deep breathing exercises to be the most commonly used modalities. These are among the most researched and accepted CAM in medical settings, and have been shown to be safe and

effective in addressing existential distress and deepening awareness. Along with the use of natural products, meditation and deep breathing exercises are among the top three CAM modalities used by the general public in North America.

All respondents, regardless of certification, age and professional settings, used a significantly higher number of CAM modalities in their personal care (38 of the 41 options listed, including a category for "other") than they did in their professional practice (12 of the 41 options listed). In the United States, massage is among the least reported modalities used by the public (McFarland et al, 2002),[12] yet it was the highest reported CAM for personal care in this study, followed by chiropractic/osteopathic. With the vast majority of respondents working in health care settings, this may be a reflection of health care benefits provided in Canada. Many also reported use of natural products for self-care (25%). No respondents used natural products in their professional practice, indicating good understanding of scope of practice and competencies. This is similar to the American study by Jankouwski, in which those who used natural products did so for self care only. Many indicated yoga as effective in self care (44%), but again, only a few (4%) incorporated this in their professional practice.

In regards to training in and knowledge of CAM, half of the respondents either indicated that they had no training in CAM or they gave no indication; while 14% indicated they have formal training, certification and professional membership with the certifying body. Almost a third of respondents indicated that they are "very" knowledgeable about CAM. Supervisors tended to report less training and knowledge than other respondents.

There seemed to be no correlation between the number of modalities used in professional practice and respondent's level of training in those modalities. Some respondent's employed a significant number of modalities with little formal training in any, while others used 1-5 modalities with formal training and certification. Using fewer modalities also did not tend to indicate a greater level of knowledge and training. Presumably, respondents who use CAM in their professional practice consider themselves qualified to do so; not fully assessing these qualifications was a limitation of the survey. For example, qualifications may be attained in traditional cultural or spiritual ways, such as through initiation, rather than through the processes of a CAM certifying body.

Comments from this survey revealed respect for scope of practice, with a range of views in the use of CAM by spiritual professionals:

- "I believe that certified specialists in CAM's can be integrated into practice of spiritual care and pastoral counseling."
- "Our spiritual health department offers CAM options to patients and they are heavily requested. "
- "Great to be exploring these things - it's the wave of the future, I believe."
- "I use energy practices that form a part of my spiritual and philosophical approach to life... I use them subtlety and not overtly."
- "I think that care needs to exercised in the use of these practices… literature on CAMs tends to assume that these are appropriate interventions for use with all clients."
- "Since I have received no formal training in any specific practice of CAM, I am less confident to use them in professional practice."

- "We need to not be so enamored with psychological therapies and alternative therapies that we lose the uniqueness and the power of our scope of practice."

Currently, CAM as a category isn't explicitly claimed within CASC/ASCC competencies, although some modalities such as prayer and meditation are included at least implicitly. The researchers recommend that further studies be done to explore members' views about claiming CAM as such, which modalities are appropriate to their scope of practice, qualifications, accountability and ethical considerations. Also, further studies could explore which CAM modalities are most effective with spiritual distress, and religious and cultural sensitivity/safety in the use of CAM with different communities.

There were a number of limitations in this study: it was a single online survey, limiting responses to those comfortable using this tool; most of the questions were quantitative rather than qualitative in nature, thus severely limiting how respondents could express themselves; diverse understandings underlying tick-box selections could not be accounted for, nor could disagreement with the options provided (e.g. including spiritual practices in the category of CAM). Building on the Jankouwski et al. study, prayer was included and assessed as a separate modality. This also helped prevent confusion between prayer and meditation. However, mindfulness was not included in the study, and would have been a valuable nuance to clarify. This study also did not include a measure of social desirability response bias.

This study was an attempt to provide insight into the use, knowledge of and training in complementary and alternative therapies among Canadian spiritual care professionals who are members of CASC/ASCC, and working predominantly in health care settings. Findings suggest a wide variance, but overall significant level of engagement, mirroring the findings of the American study by Jankouwski et al.

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