Complementary therapists' motivation to work in cancer/supportive and palliative care: A multi-centre case study

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\textbf{A B S T R A C T}

\textbf{Purpose:} To uncover complementary therapists' motivation to work in cancer/supportive and palliative care.

\textbf{Method:} The study employed a multiple case-study design, involving three cancer/supportive and palliative care settings in the North West of England. A questionnaire survey (\(n = 51\)) was undertaken, followed by semi-structured interviews with a subgroup of the sample (\(n = 28\)).

\textbf{Results:} Participants had a mean age of 50 years, were predominantly female and had varied career backgrounds, including prior professional experience in healthcare, teaching and private complementary therapy practice. Motivation for working in cancer/supportive and palliative care included vocational drive with a desire to provide individualised treatment and adopt a person centred, empowering and caring approach; disillusionment with conventional care; career development and personal experience of cancer or other serious illness.

\textbf{Conclusion:} Findings indicated that motivational factors for therapists working in cancer care/supportive and palliative care were varied and highlighted a combination of 'push and pull' factors, particularly for therapists who are also health care practitioners. Further research related to volunteering, sustainable services and support and training for therapists is required.

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1. Introduction

Many complementary therapy (CT) services in cancer/supportive and palliative care settings have their genesis in motivated individuals providing CTs as an ‘add on’ to their existing role, for example that of a staff nurse.\textsuperscript{2,3} Treatments were frequently provided on an ‘ad hoc’ basis by nurses who had undertaken a course in a therapy, primarily involving touch, e.g., massage, aromatherapy and reflexology.\textsuperscript{7} Sometimes the trigger for providing these therapies would be the nurse’s own experience of receiving a therapy, highlighting that patients, who were particularly stressed, could also benefit.\textsuperscript{11} As interest has grown in CTs, services have developed and become more formally accepted and integrated in hospices and NHS Trusts. Increasingly, therapists with no nursing or medical background are being recruited by such services.\textsuperscript{14}

Reasons for working in cancer care as a therapist are therefore likely to be complex, and, as yet, there is a paucity of information on what motivates individuals to do so. There is some literature available as to why health professionals, such as nurses, are drawn to working in cancer care; this commonly includes a desire to help others and provide compassionate care.\textsuperscript{15,5} In an exploration of hospice nurses’ narratives, Hidalgo-Kehoe\textsuperscript{8} reported that nursing provided opportunities to attend humanely in a way that they had not been able to do in other settings. Nurses wanting to develop a more therapeutic role have reported, through their work as complementary therapists, being given opportunities to develop, practice and evaluate their work.\textsuperscript{7,13} Importantly, cancer/supportive and palliative care services may have access to funding that offers opportunities for therapists to provide interventions which aim to help alleviate symptoms and enhance quality of life. Further understanding of why some therapists choose to work in cancer/
supportive and palliative care is needed to underpin future service development and therapist training.

2. Aim

The aim of this study was to explore the motivation of complementary therapists for working within the field of cancer/supportive and palliative care.

3. Methods

3.1. Study design, data collection methods and instruments

The data reported here were obtained within a larger study of complementary therapy service provision in cancer/supportive and palliative care which employed a multiple case study design (after 16). The data for the work reported here were collected by means of a questionnaire survey, followed by a qualitative phase, involving semi-structured interviews with a sub-sample of questionnaire respondents.

As no suitable instrument existed, a study-specific questionnaire was developed 'de novo', with content generated through literature review and consultation with study sites (service leads/coordinator). Instrument was piloted and minor revision undertaken prior to the main period of data collection. Data collected included demographic characteristics (age, gender, years practising CTs, current occupation and, where appropriate, occupation prior to working as a therapist). Reasons for training as a complementary therapist and working in cancer/supportive and palliative care were explored using open questions.

For collection of interview data, a topic guide was developed (after 16); selection of topics was guided by review of the literature and pooling of expertise from the project team and its Advisory Group. The interviews sought to add further depth to and allow additional exploration of the questionnaire data. Consequently, the topics addressed mirrored those in the questionnaire. For this element of the data, respondents were asked why they had chosen to work as a therapist and in cancer/supportive and palliative care, with prompts relating to such areas as specific triggers/motivating factors and perceived differences between previous/‘usual’ role and role as a therapist. Audio-taped interviews, all approximately 1 h in length, were conducted by the same researcher on each of the three sites.

3.2. Study sites

The study was conducted at three sites in North West England, which have a history of collaborative working. A brief description is given of each site as it was at the time of data collection:

3.2.1. Site 1

A hospice which was situated on three different sites. The services offered included in-patients, day therapy and out patient services. One of the sites offered a rehabilitation and support service for people affected by cancer and their carers. This site was originally an independent charity and had offered reflexology, aromatherapy and massage since 1993. In the late 1990s, it joined with the other two sites of hospice. From 2001 a coordinator was employed to work across all three sites for three days a week. The service was delivered by six nurses, one physiotherapist and 26 lay therapists. Therapies provided included massage, aromatherapy, reflexology, acupuncture, Therapeutic Touch and relaxation techniques.

3.2.2. Site 2

A specialist cancer care hospital, which was a tertiary centre for radiotherapy, chemotherapy, and surgery. A pilot service of aromatherapy began in 1997 within the hospital’s haematology departments. In 2001 with the appointment a coordinator, the service has since expanded to all departments. The service was facilitated by two clinical lead nurse therapists. Within the team, 33 therapists worked on a sessional basis; of these, 15 offered their time in a voluntary capacity and some of the paid therapists also contributed unpaid sessions. The service was delivered by six nurses, one physiotherapist and 26 lay therapists. Therapies provided included massage, aromatherapy, reflexology, acupuncture, Therapeutic Touch and relaxation techniques.

3.2.3. Site 3

A cancer care centre providing 12 week support programmes for patients, who attended for a full-day per week. The centre opened in 1990, from the start promoting the use of adapted complementary therapies alongside mainstream treatments for cancer patients and carers. Therapies offered included aromatherapy, reflexology and relaxation and initially were offered on an ad hoc basis, before moving to more structured programme in 1997. The team consisted of 24 therapists, facilitated by a part-time nurse manager/therapist. Ten therapists were paid; these included the manager/therapist, three full-time nurse therapists, four part-time nurse therapist and two sessional lay therapists. Additionally, the team included 14 volunteers, of whom 12 were lay therapists and two were nurses. Therapies available included aromatherapy, massage, reflexology, relaxation techniques and reiki.

3.3. Recruitment

Questionnaires were distributed to all therapists (n = 75) working in the three sites. Participants were asked to tick a box confirming willingness to be subsequently interviewed. Therapists were purposively selected for interview based on questionnaire responses, to ensure a range of duration of experience as a therapist, professional background and views regarding the contribution of CTs in cancer.

3.4. Data analysis

Quantitative data from the questionnaires were entered into SPSS v13.0 and analysed descriptively. The purpose of these data was to characterise the sample; given the small sample size, inferential testing was not employed.

Data from open questions in the questionnaire and from the transcribed interviews were thematically analysed using manifest content analysis. Each response was read and reread with items clustered in areas of commonality for their ‘look alike/feel alike’ quality. The final key themes were agreed by four of the authors.

3.5. Ethical considerations

Site specific research governance and managerial approvals were obtained. Formal ethical approval was given by the relevant Local Research Ethics Committee. Participants gave written consent to participate and were assured of anonymity and confidentiality, which was supported by assigning each participant a unique identifier.

4. Results

Characteristics of the participants are reported, followed by a thematic presentation of data from open questions in the questionnaires and interview data; these data have been reported.
together, as the two data collection methods were employed in a complementary manner. Figures in brackets represent the total number of participants who provided data on each theme from across the two data sources.

4.1. Participants

A total of 75 questionnaires were distributed to the sites with a response rate of 68% (n = 51). Of the 51 participants, 47 were female and 4 were male. 18 therapists worked at Site 1, 18 at Site 2 and 15 at Site 3. The age range (n = 48) was 23–78, with a mean of 50.2 years (three participants did not disclose their age). Years of practising complementary therapies ranged from less than one (n = 2), to in excess of 11 years (n = 11). The majority reported working for over 6 years (n = 28) as therapists within cancer/supportive and palliative care. Participants described themselves professionally as being nurses (n = 19), doctors (n = 2), physiotherapists (n = 3) and complementary therapists (n = 27). Some of the complementary therapists also reported that they had previously been teachers, beauty therapists, business managers and one reported having been an engineer. A summary of the demographic characteristics is presented in Table 1.

4.2. Themes

Six key themes were identified from the responses to the question ‘What led you to decide to train and practise as a complementary therapist?’ The most common theme was ‘vocational drive’ (n = 37), followed closely by ‘disillusionment/need for a different approach’ (n = 31), suggesting that these issues were powerful motivators. Another area frequently mentioned was ‘career development/employment opportunities’ (n = 25). There were three additional, though less commonly occurring, themes. Ten therapists spoke about CTs having initially been a ‘hobby/general interest’. Interestingly, only seven therapists rated ‘experience of receiving CT/own health’ as instrumental in becoming involved in complementary therapies. Equally, ‘experience of illness/cancer’ was reported as affecting choice by only nine therapists.

Items were often combined in responses, for example, wanting to offer a different approach, together with a personal experience of receiving or observing the therapy. Comments about career development, disillusionment with existing work situation and personal development also overlapped in some responses. Counts of theme specific comments are given (n =) and the various subgroups identified (CT = complementary therapist, N = nurses, DR = doctor and P = physiotherapist).

5. Vocational drive (n = 37)

A few therapists had originally practiced within the beauty industry and were now keen to expand their practice to helping people who were ill:

...to work with touch on vulnerable people not as a beauty treatment (CT34)

Some of the therapists identified themselves as either volunteers or having worked initially in a voluntary capacity. A key phrase used was wanting to help for various reasons.

...I love the idea of helping people with their healthcare and the interaction it involves (CT33)

...I want to be able to give more to patients and for myself also (CT69 N)

...I wanted to enable people to have the chance to obtain peace of mind and time out for themselves (CT44)

A therapist described, in one of the interviews, how her previous profession had become so stressful that she decided to leave, having first done some CT training:

...I just thought not doing this anymore...started as a volunteer...didn't have any paid work or anything...this is the right thing ...giving complementary therapies (CT2).

6. Disillusionment/need for different approach (n = 31)

A common reason for health professionals to seek complementary therapy training was frustration with their existing roles:

...because I was unhappy [at work] ...and felt instinctively drawn to apply for the course [holistic therapies] (CT11)

One interviewee, who thought she had done a good job as a nurse, but had become disillusioned by the task orientated and ritualistic work. She described being:

...diverted into this area of work ...using complementary therapies is ...important to me now

One of the doctors stated that a motivational factor was

...deficiencies in medical practice (CT53DR)

There were also a number of comments related to improving the patient experience and again providing interventions that helped wellbeing:

...I wished to get closer to my patients on an individual basis ...to help them, both on a physical and emotional basis (CT42)

One interviewee, a nurse, reported having helped patients in hospital by providing reflexology prior to theatre:

...they didn't need the medication at night time for helping them to relax ...it was fantastic, it really was really good (CT38)

Amongst the health professionals a typical comment from a nurse therapist was; ...wanted more of the 'hands on' holistic aspect of caring for people that I was getting less and less of in my nursing (CT58 N)

7. Career development & employment opportunities (n = 25)

For some, training in CTs opened more career opportunities and increased ways in which income could be generated

...as a means of generating income...I was newly self-employed at the time (CT72)

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Table 1

Demographic characteristics of the sample (n = 51).

<table>
<thead>
<tr>
<th>Demographic characteristic</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) Mean</td>
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</tr>
<tr>
<td>Range</td>
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</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>47</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Professional background</td>
<td></td>
</tr>
<tr>
<td>Professional complementary therapist</td>
<td>27</td>
</tr>
<tr>
<td>Nurse</td>
<td>19</td>
</tr>
<tr>
<td>Doctor</td>
<td>2</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>3</td>
</tr>
<tr>
<td>Years practising CTs</td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>2</td>
</tr>
<tr>
<td>1–5</td>
<td>21</td>
</tr>
<tr>
<td>6–10</td>
<td>17</td>
</tr>
<tr>
<td>11 or more</td>
<td>11</td>
</tr>
</tbody>
</table>

1 n = 47, 3 participants did not provide their age.
8. Hobby/general interest (n = 10)

A smaller number of therapists identified general interest, initially perceiving CT provision as a hobby, which then provided the motivation to explore this area more fully:

...general interest which led to a wish to know more and practice (CT75)

...initially as an evening course to get out of the house, to get free massage and to learn some aromatherapy for friends and family (CT10)

One of the interviewees talked about being given a book about aromatherapy for women, which sparked their interest:

...I read it that evening...I was absolutely fascinated and hooked and from that I did a little weekend course...bought text books ...and started to go on courses (CT9)

9. Illness/cancer experience/exposure (n = 9)

Participants identified personal experience of caring for a family member, as a reason for choosing to train in CTs:

...to help my mum after being diagnosed with terminal cancer (CT48)

...after looking after a close family member ...I realised that there was more needed to help each patient feel like an individual (CT46)

For therapists who were also health professionals, seeing treatments given and hearing first hand from patients about the perceived benefits raised their interest in seeking CT training:

...having experienced massage... seen it used in hospice ....I had seen positive results from patients... who felt that complementary therapies had helped them cope with their illness...restore both physical and emotional balance (CT41 N)

10. Experience of receiving CT/Own health (n = 7)

Some participants reported that they had first come into contact with the therapies through being a client themselves:

...I received complementary therapies during a very stressful time ....and decided I would like to train to be a therapist (CT45)

Very beneficial... for my own health ...impressed with effects on well being (CT1 N)

One interviewee described living with ME for years and discovering aromatherapy, which became part of:

...my own little path to sort of help myself (CT10)

A couple of participants also mentioned that in doing therapies they also experienced benefits themselves:

...Mutual therapeutic on myself as well as clients (CT39 N)

11. Discussion

In this paper therapists’ motivation for working within cancer/supportive and palliative care has been explored. The findings from this study may be of interest to services recruiting therapists, as well as those wishing to work in cancer care.

All of the therapists in this study were working in cancer/supportive and palliative care settings, our exploration of their motivation for doing so identified as key factors: vocational drive, along with a desire to provide a person centred, empowering and caring approach. For the 24 health professionals in the sample, disillusionment with ‘conventional’ healthcare and the need for a ‘different approach’ were evident. These findings echo the work of Andrews,1 who reported on private complementary therapists’ employment profiles (n = 426) and identified that, for the majority of the sample, CTs were a second career. Sixty three (14.8%) of the participants were found to be registered nurses. Andrews’ findings indicated that therapists were motivated by witnessing the perceived success of complementary therapies and a desire to help people. In interviews with a subset of this sample of nurses (n = 11), disillusionment was a key factor in electing to leave conventional healthcare. Additionally, participants identified an attraction to learning about and providing the therapies.1 Ernst4 describes these combined factors as part of the ‘push/pull’ phenomenon, drawing health care workers into complementary therapies. This ‘push–pull’ phenomenon was evident within our sample. Further understanding of this element is important in understanding whether individuals are drawn to CTs due to positive commitment to these as therapies/therapeutic interventions or rather because CTs are a vehicle for over-coming perceived limitations in a person’s own career path and/or in conventional care. Similarly, the motivations of some participants with regard to career development suggest a need for clearer career pathways, perhaps more clearly linked with training, for therapists working in healthcare.

Seeing treatments given and receiving positive feedback from patients prompted some of our participants to seek training in CTs, and subsequently to work in cancer care. Garnett10 exploring the experiences of therapists (n = 31) working in cancer care, described their activities as generating trust, being important and feeling valued by patients. Garnett’s participants’ perceptions of their work included a sense of doing something ‘constructive’, with patients commonly reported as feeling cherished, pampered, uplifted and ‘...less angry and less frightened’, p.133.9 Although rewarding, working within cancer care/supportive and palliative settings can potentially expose staff to high levels of daily psychological stressors. For doctors and nurses, this stress can contribute to burnout, associated with sustained contact with ill and dying patients, amounting at times to serial bereavement.12,9 Although not previously reported in the literature, it does appear from the data that providing therapies, well received by patients, gave job satisfaction for some of the participants. It could be argued that this work possibly provides a sense of being valued and a counterbalance to the stressors of working in cancer care. Equally, however, it raises issues regarding the need for appropriate support of therapists (e.g. through clinical supervision), especially for those who may be working sessionally as volunteers and/or not having a clinical background. It is important to acknowledge that they may not have access to an appropriate level of peer support or be equipped through training with skills to help them cope with difficult scenarios. Importantly, for coordinators of services, there are implications for the level and content of in-service training with a mixed team of health professionals and lay therapists.

In Andrews1 study, training in complementary therapies was observed to provide opportunities for therapists to have freedom and independence in their working lives. While not stated as a ‘pull
factor’ in our study, some lay therapists did say that training in complementary therapies had broadened opportunities to work in healthcare settings, whilst for nurse therapists, comments were made about the training providing opportunities to work in private practice.

There were some important limitations to this study. The characteristics of the sample were specific to the three sites in the study, although the sample was typical of therapists, with regard for example to gender. Although data were collected regarding the number of paid and volunteer therapists at each site, individual therapists’ status was not recorded, unless it was raised by the therapist. Given that several therapists identified this as a motivating factor, future studies would benefit from recording of such data. Some therapists did identify themselves as retired, with the work providing opportunities to contribute their time and skill as volunteers on a regular basis. This aspect of volunteering and its impact on the development of sustainable complementary therapy services is an important area for future research. This study did uncover that for some participants being a volunteer was not only a worthwhile and rewarding activity, but also led to opportunities for paid work as a therapist. Although not specifically mentioned by participants, it is important to consider that being a volunteer can provide valuable experience which may be looked upon favourably by potential employers.

Given that working in cancer care/supportive and palliative care is well recognised as being challenging and stressful, it is important to note that being a therapist over the longer term was not investigated. It is also important to acknowledge that the data reflected the experience of being a therapist in the three study sites, and this maybe different in other cancer/supportive and palliative care centres.

**Box 1. Considerations for clinical practice and future research**

- A mixed workforce of health professionals and lay therapists requires coordinators to tailor in-service training, mentoring and supervision.
- In recruiting therapists, motivational influences, such as personal experience of cancer and other life threatening illness, may be important to discuss at interview.
- Given that those working in cancer/supportive and palliative care are at risk from burnout, it is important that coordinators put into place support and supervision for all therapists.
- It would be useful to investigate further participants’ claims that providing complementary therapies offer a counterbalance to the stress of caring for people with cancer and other life limiting illnesses.
- The ways in which therapists feel that they make a difference and offer choices to patients could be explored further, possibly through focus groups.
- The role of the volunteer therapist could be investigated, together with recruitment, training and supervision needs specific to this group.

12. **Conclusion**

This paper reported on therapists’ reasons for working in cancer/supportive and palliative care settings. In doing so, it has highlighted a combination of ‘push and pull’ factors, particularly for health care practitioners – for example, participants’ reported disillusionment with conventional care and the attraction of individualised therapeutic treatments. For many therapists, motivating factors included wanting to help others by providing treatments aimed at improving wellbeing and relaxation. For some this was driven by their own or family experience of cancer. Further research work related to volunteering, sustainable services, and support and training for therapists is required.

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**References**