Workplace complementary and alternative therapies for hospital-site staff

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Keywords National Health Service, Hospitals, Employees, Workplace

Paper type Research paper

Abstract

Purpose – Workplace wellness schemes are emerging in NHS settings, including complementary and alternative therapy services aimed at improving employee wellbeing. The aim of this study is to explore the impact of one such therapy service on service users based at a large UK teaching hospital.

Design/methodology/approach – In-depth semi-structured interviews were undertaken with seven staff members who participated in at least one workplace complementary or alternative therapy. An Interpretative Phenomenological Analysis approach was taken in the design of interviews and the analysis of interview data.

Findings – The following themes were elucidated: having positive but tentative expectations of therapies; enhancing health and wellbeing through therapy; appreciation for the "Q-active" therapy service as part of a workplace wellness programme; and work influencing therapy use and vice versa.

Originality/value – The study adds to the limited research literature evaluating workplace health interventions by using an interview-based qualitative approach to access employees' experiences of this type of workplace complementary and alternative therapies. Valuable insights were gained about the significance of this particular aspect of a larger workplace health programme. The emergent themes build on the existing literature on individuals' expectations and experiences of complementary and alternative therapies and also on the potential benefits of such a service for workplace health promotion.

1. Introduction

Workplace health promotion programmes are growing in popularity as a method for improving population health in a "settings" approach to health promotion. The "Choosing Health" White Paper (Department of Health, 2004) highlights the need for employers to improve the quality of the working lives of UK employees, specifically aiming to make the National Health Service (NHS) a pioneer in workplace health promotion.

Although workplace health programmes vary significantly in terms of content, duration and intensity (Heaney and Goetzel, 1997), both employers and employees stand to gain benefits from a healthy work culture. Clinical and cost benefits have been documented from workplace health programmes (Pelletier, 2005). Some health and wellness campaigns for employees have given employers a positive return on their investment due to falls in absenteeism (Aldana et al., 2005) and cost-saving relating to reduced health-care service utilisation by staff members following participation (Ozminkowski et al., 2002). Other reported benefits of workplace health promotion interventions include staff having a more positive attitude towards their employer and greater job satisfaction (Ho, 1997).

Specifically in an NHS setting, workplace wellness interventions are helping to change organisational "health culture" in line with corporate social responsibility and a focus on both individual and organisational gain from such schemes (Blake and Lloyd, 2008). One local example is Q-active, a multi-faceted, award-winning workplace health initiative. This theory-driven programme serving 11,000 employees over two sites of an NHS Trust aims to: promote organisational change in the health culture of the organisations; provide encouragement and empowerment for staff to

lead healthy working lives; improve the perception of the organisation by staff and by the community; reduce costs relating to sickness absence and lost productivity; and increase staff psychological and physical well-being and job satisfaction. The components of this programme are based on an ecological model of health, and include physical activity interventions, complementary and alternative therapies, health screening, health promotion campaigns, environmental interventions to promote stair use and organisational and policy changes. This study assists in the evaluation of the complementary and alternative therapy aspect of the Q-active programme.

There is considerable variability in current working definitions of complementary and alternative medicines ([CAMs] House of Lords Select Committee on Science and Technology, 2000). However, one useful description offered by the National Centre for Complementary and Alternative Medicines (NCCAM) is that "CAM is a group of diverse medical and health care systems, practices and products that are not presently considered to be part of conventional medicine" (NCCAM, 2007, p. 1). Whereas complementary medicine practices are used alongside conventional medicine, alternative medicine practices are designed to provide a different treatment to the conventional medical approach (NCCAM, 2007).

CAM use is a growing phenomenon according to population surveys in a number of developed countries (e.g. Eisenberg et al., 1998; Nilsson et al., 2001). It is difficult to delineate UK trends in CAM use, due to methodological differences between existing studies (Emslie et al., 2002). Nevertheless, Emslie and colleagues found an increase in CAM use over a five year period in Scotland. While it is not currently possible to say if CAM use is on the increase in the UK, it seems as though CAM has gained a reasonable foothold in terms of healthcare expenditure in the UK, with one estimate

being that ten per cent of the UK population solicit the services of a CAM practitioner every year (Thomas et al., 2001).

There are a myriad reasons that CAM users cite for using these therapies. CAM therapies are sought as a treatment for medical conditions, both alongside and in the place of conventional medicine (Thomas and Coleman, 2004). Such therapies are also used to promote general well-being (Eisenberg et al. , 1998) and to achieve a more holistic approach to treatment (Vincent and Furnham, 1996). In addition, CAM therapies are often used as a means of stress-reduction and relaxation, or for non-health reasons such as "going for a treat" (Thomas et al. , 2001). Factors such as a higher level of education, poorer health status, and congruence between people's health/life-related beliefs and the philosophical orientation of these therapies may predict the uptake of CAM therapies (Astin, 1998).

While the evidence for outcomes of workplace CAM use is limited, some studies have reported psychological and physiological benefits of participation in such schemes, particularly in the area of massage therapy. Early studies demonstrated positive outcomes for health and well-being. For example, one study of workplace stress-reducing techniques offered a ten minute chair massage to staff working in a public hospital. Participants scored lower on anxiety, depression, fatigue and confusion measures post-treatment and scored higher on a measure of vigour (Field et al. , 1997). Other small scale trials of massage therapy among employees have suggested that on-site massage therapy may encourage physiological reactions such as lowered cortisol levels (Field et al. , 1996) and reduced blood pressure (Cady and Jones, 1997), indicating that the therapies had a relaxing effect.

In a more recent, larger scale randomised controlled trial of massage and acupressure in the workplace, similar reductions in physiological measures of blood pressure and

heart rate were found in the treatment group, as well as reductions in psychological measures of anxiety and depression (Hodge et al. , 2002). Participants also reported a number of benefits from their participation in the treatment arm of this study including enhanced well-being and improved sleep patterns.

The impact of introducing more comprehensive and diverse CAM therapeutic services into a hospital work setting has not been extensively researched. One formative study in this area by Wilson et al. (2007) does provide a valuable insight into the introduction of one such service in an NHS cancer centre in England. Key benefits for service-users included: symptom relief; enhanced feelings of control, self-awareness and self-esteem; better coping; and increased relaxation and happiness. Both users and non-users felt that the availability of this service reflected an employer that was concerned about staff well-being. Some staff reported that they were too busy to find the time to avail of this service, while others called for increased availability of sessions. While key lessons about the value of a CAM therapy service for healthcare staff can be drawn from this study, the authors stipulate that if funding had permitted, they would have liked to supplement their questionnaire findings with interview data to increase the depth of knowledge gained about participants' experiences with this service.

The present study focused on the CAM therapy service offered through the Q-active health promotion programme. Established in 2006, this service was accessible to employees of the University of Nottingham staff and Nottingham University Hospital NHS Trust (NUH Trust) who were based within the hospital setting at the time of the study. The service incorporated the following range of CAM therapies: aromatherapy; back massage; crystal therapy and chakra balancing; Indian head massage; leg and feet massage; reflexology; reiki; and Swedish body massage. Three therapists

provided these services on a part-time basis and all therapists were employed on a part-time basis in other job roles within the NUH Trust, thus creating a service led by NHS staff for NHS staff. While the potential positive benefits of such a service in terms of staff health was demonstrated through a four week in-house pilot study of massage therapy with 33 staff members (McGivern, 2003), the complete Q-active CAM service has not yet been evaluated. The aim of this study, then, was to explore the impact of the Q-active CAM service on the daily lives of staff who use this service and to examine the meanings which staff members attribute to their experiences with these therapies.

2. Method

2.1 Study design

Previous research in the area of CAM use has often concentrated on measuring the value of such services on pre-defined scales of physical and psychological well-being. With this in mind, a qualitative approach was employed in the present study to further explore the more personal meanings which may be attributed to a work-based CAM service. In-depth semi-structured interviews were carried out to access service users' views on this service. Smith's (1996) Interpretative Phenomenological Analysis (IPA) was used to inform the design of the interviews and analysis of interview data, as it is an approach that allows exploration of the day-to-day personal meanings attributed to specific events/topics. It is a suitably exploratory methodology due to its emphasis on a bottom-up approach to understanding participants' experiences.

2.2. Participants

Participants were recruited from one hospital worksite of NUH NHS Trust. Six females and one male took part with ages ranging from 21 to 64 (mean =44). This sample size is consistent with the aims of the in-depth analysis method of IPA (Smith, 2004). The primary researcher had a background in health psychology but had no previous experience using CAM therapies. She was not affiliated with the Q-active programme. Interviewees worked from 21 to 55 hours a week (mean . 39:25 hours). Four interviewees worked in administrative roles, two were medical doctors and one worked in a laboratory. Two of the staff who worked in administration were employed by the University of Nottingham but worked on the NUH NHS Trust worksite. All remaining participants were employees of the NUH Trust.

All participants reported some use of complementary or alternative therapy before they began using the Q-active therapy service. The Q-active therapies that interviewees had sampled included: aromatherapy, back massage, face massage, foot massage, Indian head massage, reflexology, reiki and Swedish massage.

2.3 Interview procedures

Interviews took place at the same hospital worksite and lasted between twenty five and thirty five minutes. A semi-structured interview schedule was constructed in order to guide the content of the interviews. This schedule was used in a flexible manner to allow exploration of interesting topics arising during the interviews. Participants were asked to discuss in detail their first experience with any type of CAM therapy and their first and/or most recent Q-active therapy session. Participants were asked about their expectations or reasons for availing of the therapies, their reflections on the therapeutic proceedings and how they felt after the sessions. Interviewees were also asked to reflect on their plans for future use of this service.

Focusing on detailed description of particular events allows interviewers to delve into the subjective meanings participants attribute to the topic under investigation (Kvale, 1996). Rooting the dialogue in a particular experience allows the discussion to move from the general to the specific and thus closer to the subjective meanings of events for each participant (Flick, 1998).

Each interview was transcribed verbatim. Every comment by the interviewer and the participant was documented, including utterances such as “em” and “emhem”. Overlapping speech was also indicated. For the purpose of brevity, in the extracts presented below, the interviewer’s encouraging prompts are excluded.

2.4 Ethical issues

Ethical approval was gained from the Ethics Committee at the Institute of Work, Health and Organisations at the University of Nottingham. Research Governance approval was obtained from NUH Trust Research and Development Department. Participants were provided with consent forms that outlined the nature of the study, that the interviews would be taped and that they could withdraw from the study at any stage. In order to preserve the anonymity of participants, pseudonyms are used in the transcripts and write-up.

2.5 Data analysis

Interview data were analysed using Interpretative Phenomenological Analysis ([IPA] Smith et al. , 1999). In keeping with the idiographic approach that is characteristic of IPA (Smith, 2004), each interview was analysed in detail before looking for communalities between interviews. This involved careful reading and re-reading of the interview transcripts. Initial codes were jotted down in the left-hand margins of

each transcript. After subsequent readings of the scripts, themes that reflected the meaning of the experience for the participant were marked in the right-hand margin of each transcript. A master list of themes for each interview was then drafted. This process occurred with each transcript, with themes being added or dropped according to their prevalence and importance to the participants' stories, until no new themes emerged. A master list of themes encompassing all interviews was then constructed, which included examples from the text of the occurrence of these themes. Emerging themes were compared both within and between interviews to enhance the sensitivity of the analysis. Throughout the analysis and subsequent write-up, the role of the researcher in co-creating the interview dialogue was considered and acknowledged, in accordance with the reflexive nature of the analysis (Smith, 1995).

3. Emergent themes

The four main themes elucidated in relation to participants' experiences of the Q-active therapies will now be presented: "Having positive but tentative expectations of therapy"; 'Enhancing health and well-being through therapy'; 'Appreciation for the Q-active therapy service'; and "Work schedule influencing therapy use and vice versa". Relevant examples from the interview data are included for illustrative purposes. In these extracts, " . . . " indicates the omission of an encouraging prompt, ". . . . . " indicates removal of a section of dialogue. The initial "O" refers to the interviewer and all other initials refer to the pseudonyms of the respective participants.

3.1 Having positive but tentative expectations of therapy

All participants revealed that they were seeking or hoping for some degree of help with managing health problems by attending CAM therapy sessions. The type of help sought or expected varied. Many participants expected symptom or pain relief. Linda, when asked about her reasons for starting massage, describes how she sought massage therapy to aid her recovery from an acute illness:

L: I would have been out of action maybe physically . . . I had an expectation of feeling better.

Apart from managing physical aspects of ill-health, the majority of participants also had positive expectations of therapies in terms of their potential for relaxation and stress- reduction. Tara responds to a question about her expectations of the therapies:

T: . . . some of the therapies I expect to just calm me down . . . and take some of the stress out of my current daily working life.

Tara's uses the phrases "just to calm me down" and "take some of the stress out" to describe the stress-regulating benefits she expects from the therapies. In doing so, she attributes agency to the therapies as having an ability to reduce stress, rather than claiming personal control over her stress levels.

In addition to the many positive expectations participants had of the therapies, most also expressed a degree of uncertainty. This uncertainty was evident in a number of ways, including cynicism about how the therapies work, nervousness, and uncertainty about the level of instruction that can be given to the therapist by the client. Adam

discusses how he felt about attending his first massage session:

A: Eh I suppose a little bit nervous about what to expect . . . the first time I went was on the advice of my G.P. . .who said you know this might help . . . so I went along as a cynical medic

O: . . . because you hadn't tried it before or?

A: I hadn't tried it before and you know it's on the sort of grey zone.

Despite receiving a positive recommendation from his G.P. about the potential benefit of the therapy, Adam "went along as a cynical medic", a phrase which highlights his caution about expecting benefits from this session. He expands on his rationale for being cynical about the therapies with the metaphorical phrase "on the sort of grey zone", which highlights his ambivalence. While mixed expectations of the therapies emerged from participants' stories, there was also a strong element of surprise at the amount of benefit participants experienced, indicating that expectations may have been exceeded. Linda describes her expectations of reflexology:

L: . . . they usually know things before my body tells me. . .

O: Like what kind of things?

L: . . . I mean it sounds ridiculous but em they sort of press around and say oh you know you've got a problem with your upper torso . . ..

O: And had you expected that they would be able to do things like that or?

L: I suppose not the first time . . . I was surprised at the knowledge that they did have although I probably read about it.

Linda has come to expect her therapist to be able to identify her health problems before she does herself, something she did not expect at her initial session, even though she may have been aware of the possibility of such a benefit. Her surprise is echoed in her comment that "*it sounds ridiculous*" in relation to the therapist's ability to locate health problems by working her feet.

3.2 Enhancing health and wellbeing through therapy

A dominant theme across the interviews was the use of therapies to promote health and well-being in a variety of ways. A key use of therapies for all participants was to facilitate physical or psychological relaxation. Catherine describes how she felt on her first session of reflexology:

C: . . . I ended up falling asleep . . . you know it's just how relaxing it is.

Besides finding therapy sessions themselves relaxing, many participants discussed the carry-over effects of the session in terms of relaxation and stress-relief outside of therapy sessions:

T: . . . even on my lunch break . . . I can just sit there and just at the desk in my office and just use the technique. . .just to calm down.

Apart from using therapies for physical and mental relaxation, participants also sought to manage specific health problems. Sharon, like many other participants, experienced symptom relief when she attended reflexology:

S: There were certain points on my feet that were very tender . . . and I asked her . . . what do you think those points were. . .she said oh this is your shoulder and these are your sinuses . . .and it was true I had problems there I hadn't actually told her all the problems . . . but they were things she picked up . . . and over time those pressure points became less sore and my symptoms in those areas improved.

Sharon went to reflexology seeking relief from her foot pain. In addition to experiencing relief from this pain as a result of this session, problems with other parts of her body were also ameliorated. She therefore gained both expected and unexpected relief from health problems. Participants also reported the use of therapies to promote their health by helping them to stay well and avoid illness. Fiona, when asked if she had any expectations of a chiropody session, replied:

F: . . . visiting them I thought I would take more of a pro-active . . . kind of maintenance check-up type thing a human M.O.T.

Fiona compares her use of the therapy to an M.O.T. (an annual car safety test in the UK which checks whether cars are roadworthy). In this respect, Fiona may see this therapy session as a similar acid-test of her current health status and is taking a "pro-active" approach to preventing health problems.

A running sub-theme that emerged from all participants' discussion of their patterns of therapy use was a desire to maximise the benefits they received from the therapies. Interviewees achieved this in a number of ways, including: experimenting with therapies to find the most beneficial one; sticking with the most beneficial therapy;

alternating therapies so as not to become tired of one type of therapy; and acting on therapists' advice to promote health. For example, when Margaret is asked about her plans for future use of the Q-active therapies, she comments:

M: . . . I tend to stay with the body massage . . . because that's what I enjoy . . . and I feel most benefit from.

By choosing "to stay with the body massage", Margaret is attempting to maximise the benefit she receives by attending the therapy sessions, as this is the type of therapy that she finds to be the most beneficial.

3.3 Appreciation for Q-active therapy service

Interviewees' appreciation for the Q-active therapy service was evident in all of the participants' accounts of their therapeutic experiences. This theme of appreciation emerged through, for example, comments on the convenience of having the service on-site. Fiona describes her first reactions to the service:

F: . . . I was just so delighted to have something local on premises it was like oh fantastic . . .and I don't have a lot of time for you know traipsing over to even main campus . . . would be quite a trek.

The idea of having to solicit therapy services outside of the workplace is portrayed as problematic. The use of the words "traipsing" and "trek" contrast significantly with the terms "delighted" and "fantastic", which she uses to describe her enthusiasm for the on-site service.

This theme of appreciation was also demonstrated through participants' praise of NUH Trust's initiative as an employer in providing this service, and through their experience of feeling valued by their employer as a result. When asked at the end of his interview session if he had any further comments about the therapy service, Adam adds:

A: . . . I'd be a great supporter of them . . . anything that the employer can do to lower the stress and to lower the . . . tension and increase morale I think it's very forward thinking.

Adam appreciated the pro-active approach of his employer in helping to prevent work-related stress and in creating a positive work environment for employees by "increasing morale". Some participants expressed their appreciation for the Q-active therapies by praising the therapists themselves:

A: . . . they're very understanding. They've worked in the health system themselves . .. em and you know I can't speak highly enough of them really they're very accommodating.
O: And that's important for your schedule?
A: Em yeah it's crucial because . . . I just find it very difficult to say I'll be here at five fifteen. . . and be absolutely sure that I'll be there at five fifteen.

Adam's busy work schedule could potentially hinder his access to the therapies. However, he appreciates the understanding that the therapists have of the health

system and their accommodating nature regarding therapy times. An important aspect of the Q-active therapy experience for three of the participants was an appreciation of privacy in the therapeutic sessions, as demonstrated here in an excerpt from Sharon's description of her first massage session:

S: . . . It was not busy at that time . . . there wasn't anything else going on so it was quite nice to feel because obviously if you're getting stripped . . . in a place where you know lots of people . . .

Sharon appreciated the quietness of the surroundings because, due to the on-site location of the therapy service and her acute awareness of the potential presence of work colleagues in the vicinity of the dedicated "Well-Being Room", undressing for the therapy may be an uncomfortable experience. For two other participants however, the privacy of therapeutic environment is not always ideal. For Catherine and Fiona, the location of therapy sessions in partitioned-off areas of the large Q-active Well-Being Room can be problematic. Catherine describes her discomfort at one particular session due to the noise of another event taking place in the room at the same time as her session:

C: . . . there was this one time when I went and they had em kind of wellness checks the other side of the screening you know . . . and people were being a bit noisy and it was a bit frustrating.

Fiona, when asked if she had anything else to add about her experience of Q-active

therapies added, felt that the availability of a specific designated room for the therapies would enhance the current service:

F: When are we going to get a dedicated area? . . . it would be nice to have some purpose built rooms . . . If you fancied something like that and the room was available it would be great to book.

3.4 Work influencing therapeutic experience and vice versa

The interaction between work and therapy use was a theme that was common across all of the interviews. This was not a one-way process – while work routines seemed to influence participants' use of therapies, it can also be seen that the therapeutic experience had an effect on their working lives. The influence of interviewees' work schedules on their use of the Q-active therapies varied from one participant to the next. Some found that their work-schedule had the potential to limit their therapy use, as evidenced by Tara's response to a question about her intentions to use other types of Q-active therapies:

T: . . . em I've never had time to do anything else . . . I'd sort of looked and thought well I'd quite like to have a go at that . . . there doesn't seem to be enough appointments . . . to fit in with what I can . . . clear my desk time enough to go and do it . . . especially because just we're so stressed.

Tara's enthusiasm to use the therapies is compromised by the difficulties she encounters when co-ordinating sessions. She finds it hard to put work aside and make

time for the session, which is compounded by high levels of stress at work. She also feels that a lack of availability of therapies at suitable times makes it harder to co-ordinate sessions that fit her schedule. The stress of a busy work schedule also seemed to mediate some participants' experience of the Q-active therapy session itself. Sharon, for example, discusses her first experience of massage session:

S: I had a back massage here . . . which was good . . . but I think it's sometimes difficult for me. I think I was rushing from work and I still had to go back I remember . . . so sometimes the relaxation that you would have perhaps if you were doing it outside work isn't there.

Sharon is positive about the Q-active therapy but has reservations about the level of relaxation she can get from such sessions, compared to similar sessions outside of work. She describes "rushing from work" to get there and having to return to work afterwards. This suggests that she was under pressure to fit the session into her work schedule. While some interviewees' work schedules had a negative impact on their therapy use, others found that their particular work schedules, or the availability of therapy sessions, facilitated their use of these on-site therapies. For example, when asked how the therapy times suited her, Catherine replied:

C: That's fine because you know they've got quite a bit of flexibility and I've I get an hour for lunch . . . there are some of them therapies you know that are like only half an hour or shorter . . . so that people can have a chance to get to these therapies if they like . . . to chill out and it does kind of help with the job and everything.

Catherine feels that her lunch-hour allows her the freedom to attend the therapies and she appreciates the flexibility of the session times, as evidenced by her comments about the short duration of some of the therapies. Catherine's comments summarises the theme as a whole. Specifically, although work schedules did influence therapy use, therapy use also influenced working life for many of the participants as is evidenced in the previous three themes.

4. Discussion

Through the use of semi-structured interviews and Interpretative Phenomenological Analysis, an insight was gained into staff experiences of using Q-active CAM therapies. Interviewees had positive expectations coupled with some uncertainties about starting any new therapies. Participants used therapies for diverse reasons to improve various aspects of their health and well-being and were highly appreciative of the service. An important aspect of participants' experiences with the therapies was the mediating effect that work had on therapy use, and equally the impact that therapy use had on life at work.

These findings are consistent with much of the existing research in the area, both on CAM therapy use in general and on workplace health interventions. Specifically, participants used therapies to help them manage illness, both as an alternative to seeking medical treatment and to complement current medical treatments (cf. Astin, 1998; Thomas and Coleman, 2004). Interviewees also utilised therapies to maintain their health (cf. Eisenberg et al., 1998) and to gain relaxation, manage stress and to feel they were doing something enjoyable for themselves (cf. Thomas et al., 2001). Consistent with previous research on workplace health interventions (e.g. Ho, 1997),

participants felt this service enhanced their working lives and improved their perception of the NHS as an employer. In terms of complementary and alternative therapies in the workplace, participants in this study also discussed the relaxation or stress-reduction benefits experienced by employees in previous research (cf. Field et al., 1997; Field et al., 1996; Hodge et al., 2002). As in Wilson et al. 's (2007) study of a multi-faceted complementary and alternative therapy service for staff at an NHS cancer centre in England, participants in this study experienced a wide range of benefits including symptomatic relief, enhanced relaxation, feeling positive, and an increased ability to manage their own health.

However, in interpreting the results of the present study it is important to bear in mind that the CAM therapy service in question was only one part of a large-scale workplace wellness initiative, based on an ecological model of health. Such comprehensive health promotion models are multi-faceted, concerned with promoting an organisational "health culture" based on environmental change and policies that support employees in making healthy choices in their daily lives. Due to the fact that such workplace initiatives are becoming more commonplace across the UK, both in NHS and non-NHS settings, it is important that the results of evaluations of single aspects of such initiatives acknowledge the broader health promoting organisational culture within which such services are situated.

This study adds to the existing literature in a number of ways. The qualitative interview-based design, informed by Interpretative Phenomenological Analysis (Smith, 1996), was a novel approach to this topic which facilitated the gathering of rich information on the subjective meanings that participants attached to their experience of this workplace CAM service. This was an especially useful technique to address some of more sensitive topics such as health and work-related stress.

By utilising this methodology, further insight was gained into some of the well documented aspects of CAM use in the workplace such as relaxation benefits. In the current study, the relaxing effect of therapies manifested itself in many inter-linked ways, including feeling relaxed in the therapeutic session (both physically and psychologically), applying relaxation techniques learned through the therapies in the workplace, and the impact of a busy work schedule on relaxation. Therefore, by adopting this qualitative approach, a more in-depth understanding of the day to day meanings attached to workplace CAM therapy use was gained.

The use of semi-structured interviewing and IPA, however, is but one way in which the study of workplace complementary and alternative therapies could be approached. This method was chosen due to the exploratory nature of the research topic, the short time that the therapy service has existed and the lack of qualitative literature on participants' experiences of workplace CAM therapies. In keeping with the reflexive nature of IPA enquiry, it must be noted that the representation of participants' experiences in this paper is a product of a co-created dialogue between the researcher and study participants. While all attempts were made to maintain and display a reflexive account of participants' experiences, in order to help readers understand the context of the documented experiences, no claims can be made for the generalisability of these findings to all therapy users.

In response to the needs of the Q-active team to further evaluate their therapy service, future research could include a quantitative needs-based assessment of current therapy users to identify any practical changes that can be made to improve access to the services. As this study focused on existing service users, another fruitful area of enquiry may be to carry out a wider study from a sample of staff members (including non-service users) to determine if there are any particular barriers to

therapy-use that prevent staff from gaining the benefits that were so appreciated by the participants in this study. Another point which this study raises is that each participant interviewed had some experience of using CAM therapies outside of the workplace. Therefore a further area of inquiry could be to examine how many current users of this service have previous CAM therapy experience outside of the workplace and how many tried them for the first time when this workplace service was offered. Therefore further information about the profile of workplace CAM users could be obtained and used to target the future promotion of the service among employees. Further studies could employ quantitative measures of physiological health (e.g. blood pressure, heart rate, etc.) and validated measures of psychological well-being (e.g. to assess stress, etc.) in order to examine changes in health status which may arise from the use of a work-based CAM therapy service.

The novel approach to staff well-being that is presented in this study has proven quite beneficial for the consulted service users. As such, further investigation of workplace-based CAM therapies is warranted in order to ascertain the value of such services, both for the employees that avail of them and the employers that provide them. Given the health benefits reported by participants in this study, the importance of work-based health interventions to the practice of health promotion at large should not be underestimated.

Acknowledgements

The authors would like to acknowledge the assistance of the Q-active health promotion team at Nottingham University Hospital NHS Trust. In particular, we would like to thank Dr Mark Batt (director), Dr Sandra Lee (programme manager) and the Q-active therapists for their support.

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