Alternative Health Care Practices of Patients Who Attend Nurse Practitioner Clinics in North Mississippi

Wesley Barrett

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ALTERNATIVE HEALTH CARE PRACTICES OF PATIENTS WHO ATTEND NURSE PRACTITIONER CLINICS IN NORTH MISSISSIPPI

by

WESLEY BARRETT

A THESIS

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Alternative Health Care Practices of Patients Who Attend Nurse Practitioner Clinics in North Mississippi

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This entire endeavor would not have been possible without the help of my Savior Jesus Christ, who is my friend and my Lord.

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Abstract

As many as one out of three Americans uses alternative health therapies. The purpose of this study was to describe the type and frequency of alternative health care practices and sociodemographics of patients in nurse practitioner clinics in North Mississippi in order to determine implications for nurse practitioners. Leininger's Theory of Cultural Care Diversity and Universality served as the conceptual framework for this study. The researcher, using a descriptive study design, sought to answer the following questions: 1) What are the characteristics of patients who use alternative health care practices? 2) What types of alternative health care practices are being used by patients who attend nurse practitioner clinics? and 3) What is the frequency of alternative health care practices for patients who visit nurse practitioner clinics? A convenience sample of voluntary participants was identified in two nurse practitioner clinics. The sample consisted of 66 rural and 47 urban patients for a total of 113. Patients were surveyed
using the Barrett Folk Alternative Health Information Survey. Findings related to the frequency of alternative therapies concluded that there were no differences in the usage of alternative therapies between the rural and urban clinics. Statistical significance was shown in relation to income and race for the frequency of alternative therapies. The findings of this research study indicated that alternative therapy use is common among the patients that attend nurse practitioner clinics both rural and urban in North Mississippi. The data indicated that the patients who used alternative health care practices were predominately white, with an annual income greater than $40,000. A qualitative question revealed respondents thought diet and exercise were important in maintaining health. Further research is recommended using a larger sample, larger geographical area, and using a tool with established reliability.
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Chapter I
The Research Problem

There are 37 million Americans living without health insurance. Baby Boomers will start reaching the age of eligibility in 2010 and 30 years from now enrollment in Medicare is expected to grow from the current 31 million to more than 52 million, which is about one fifth the current U.S. population. The current elderly population is expected to more than double early in the next century which will affect the current health care system, causing rapid change and potential dissatisfaction with health care (Stahl, 1995). While the future of Medicare is uncertain, many critics contend that managed care will limit access to health care and will not provide the best options to achieve optimal health care. With all these uncertainties, costs, and dissatisfactions, Americans are seeking alternatives to conventional medicine (Baxley, 1996).

Over the past few years, the use of alternative therapies has become increasingly prevalent. With the expansion in this prevalence, Congress established the
National Institutes of Health Office of Alternative Medicine (NIH) in 1992. The goal of the NIH is to study alternative health care practices and compare them to conventional biomedicine. Currently the U.S. Food and Drug Administration (FDA) regulates homeopathic medicines. The FDA has established a pharmacopoeia of recognized homeopathic drugs, many of which can only be obtained by prescription. However, there are other alternative therapies not regulated by the FDA, such as nutritional supplements and herbs (Cimons, 1996).

Eisenberg et al. (1993) found that one out of three Americans uses unconventional therapies. Over the past few years such enormous popularity for alternative therapies has generated much controversy. While some studies exist in medical literature about herbs, there are very few studies about folk alternative therapies. The purpose of this study sought to describe the type, frequency, and sociodemographics of patients using alternative therapies in nurse practitioner clinics in North Mississippi. The health care impact of the use of alternative therapies in relation to care provided by nurse practitioners will be determined.
Introduction to the Problem

Traditional folk medicine has been handed down from one generation to another. Becerra and Iglehart (1995) performed a descriptive study which identified that folk medicine could be found in each ethnic group. Chinese Americans base many of their folk medicine practices on the balance of hot and cold forces in the body. Becerra and Iglehart (1995) reported studies in which the Chinese felt they could repair the body from the effect of disease by selecting either foods that had body heating qualities or foods having qualities that cool the body. The study by Becerra and Iglehart (1995) revealed that in Chinese families a combination of folk medicine practices and modern medicine was used.

Watson (1984) noted African Americans also use folk medicine simultaneously with modern medicine. African Americans perceive illness as an imbalance in the natural system and that balance can be restored through natural or herbal remedies in order to cure the illness. Many African Americans involve religion in many of their unconventional therapies.
As described by Becerra and Iglehart (1995), the Mexican American belief system is based on religion, magic, and emotional causes of illness. Rubel (1990) indicated that in a traditional Mexican culture certain illnesses were deemed incurable with Western medicine which could be cured with folk medicine. Spicer (1977), who studied the white non-hispanic belief system, found that white non-hispanics were interested in folk medicine as a relief from illness. They viewed folk medicine as a way to take charge of their own care and home treatment.

While folk medicine is often viewed by individuals as safe, studies do not demonstrate consistent safety. Cook and Baisden (1986) surveyed 170 patients and identified that patients who use folk medicine before seeing a health care provider may impede proper diagnosis and delay the treatment of a potentially serious disease. The researchers also revealed that the majority of the respondents were currently using folk medicine to treat illnesses. Cook and Baisden (1986) indicated that folk medicines which the respondents reported had the definite potential for causing serious morbidity and even death.
A more recent study by Eisenberg et al. (1993) found an estimated 1 in 3 persons in the adult population uses some type of alternative unconventional therapy. Unconventional therapy use was greater in total number of visits than conventional treatment given by primary care physicians nationwide. One in 4 Americans who did see a medical doctor also employed unconventional therapies (Eisenberg et al., 1993).

Nurse practitioners should recognize that patients often fail to reveal the use of alternative therapies. Nurse practitioners should be concerned with learning about natural alternative health care their patients may use such as folk medicine (Hucbscher, 1994). Once nurse practitioners understand that alternative therapies have been used by the patients, the nurse practitioner can elicit data which will enable them to treat patients more holistically and potentially prevent harm to their patients. People are in continuous search of relief and ease from their illnesses and may seek alternative therapies as a form of self relief. This study will explore and describe the characteristics, frequency, and type of alternative therapies used by patients of nurse practitioners.
Significance to Nursing

Leininger states that a researcher needs to discuss and explain meanings and patterns of culture care from different cultures (Reynolds and Leininger, 1993). An inquiry into folk alternative therapies will help generate invaluable knowledge for nurse practitioners to assist clients in reaching their optimal health. Therefore, this inquiry will increase the nurse practitioner's understanding of the people in urban and rural North Mississippi concerning folk alternative therapies.

A major assumption of Leininger's theory is that clients who deviate from the use of conventional medical care need nursing care which is holistic, culturally based care with which the client is familiar (Reynolds and Leininger, 1993). By using the conclusions described by this study, the nurse practitioner can be more sensitive to patients by using a culturally based plan of care. Culturally congruent nursing care should result in an enhanced understanding of the client's needs by the nurse practitioner. No literature was identified in which patients who were seen by nurse practitioners have had their alternative health care practices reported. The use of
alternative therapies for patients in Mississippi has not been identified in the literature. This study will describe the type, frequency, and sociodemographics of patients using alternative therapies in nurse practitioner clinics in North Mississippi.

Theoretical Framework

The purpose of Leininger's Theory of Cultural Care Diversity and Universality is to identify similarities and differences in care among varies cultures. Through open naturalistic inquiry of these cultures, nursing knowledge is generated (Reynolds & Leininger, 1993). The goal of the theory is to provide culturally congruent nursing care in order to improve nursing care to persons of different ethnic backgrounds through culturally based care. Leininger maintains that care is the essence in nursing and that care and culture are inextricably linked (Reynolds & Leininger, 1993).

Several of the assumptive premises of Leininger's Culture Care Theory are germane to this research study. Leininger defines cultural congruent nursing care as "those cognitively based assistive, supportive, facilitative, or
enabling acts or decisions that are tailor-made to fit with an individual's, group's, or institution's cultural values, beliefs, and lifeways in order to provide meaningful, beneficial, and satisfying health care, or well-being services" (Reynolds & Leininger, 1993, p. 20). Leininger defines culture as actions learned, shared, and transmitted values and beliefs or a particular group that guides one's thinking and decision making. Leininger also points out that cultures have generic folk systems which are learned. Folk knowledge and skills should be used to provide facilitative acts to improve a client's health condition or maintain one's well being. Culturally congruent nursing care occurs only when culture care patterns, expressions, or values are known by the nurse and are used appropriately and meaningfully. Cultural care values and beliefs are influenced by religion, kinship, education, economic, and environmental context of a particular culture. In order to provide culturally congruent nursing care to the North Mississippi culture, cultured care values must be explored by the nurses and nurse practitioners of the area.

Another assumptive premise of Leininger' theory is cultural care preservation, which will allow the nurse to
help clients retain and preserve their health through congruent care values. Understanding the type of alternative health care practices of patients will enable nurses and nurse practitioners in the area to plan safe, culturally based care for clients by recognizing the use of alternative health care practices in that culture. Culturally planned care is congruent with Leininger's definition for cultural care repatterning or restructuring. Repatterning or restructuring refers to enabling professional actions that help clients modify their lifeways for beneficial health care patterns providing a more improved lifeway. These professional actions must respect the client's cultural values and beliefs (Reynolds & Leininger, 1993).

Leininger states that a researcher must discover and understand meanings and patterns of cultured care from different cultures. This discovery can be done through quantitative, descriptive research methods which would then allow for further explication of cultured care meanings, expressions, and patterns. Leininger predicts that nurses could discover unknown or taken-for-granted features of nursing care modes through in-depth studies of the different cultures in the world (Reynolds & Leininger, 1993).
The current study describes the type, frequency, and sociodemographics of patients using alternative therapies in nurse practitioner clinics in North Mississippi. This increase in knowledge will help to provide a basis for culturally congruent nursing care (Reynolds & Leininger, 1993).

**Assumptions**

1. Patients may use alternative therapies to control their own health.
2. Alternative health care practices may vary from culture to culture.
3. Clients will honestly express their use of alternative health care practices.

**Statement of the Problem**

The frequency, characteristics, and type of alternative health care practices being used by patients in nurse practitioner clinics is unknown.

**Research Questions**
The researcher has formed three questions to be answered during the course of this descriptive study. The questions are as follows:

1) What are the characteristics of patients who use alternative health care practices?

2) What types of alternative health care practices are being used by patients who attend nurse practitioner clinics?

3) What is the frequency of alternative health care practices for patients who visit nurse practitioner clinics?

Operational Definitions

*Alternative health care practices* - remedies such as general unconventional therapies, herbs, orals, topicals, and spiritual or religious practices to promote health and wellness as measured by the Barrett Folk Alternative Health Information Survey.

*Patients* - patients who can state they are over 18, who can speak English and are able to read the Barrett Folk Alternative Health Information Survey.
Nurse practitioner clinics - clinics that employ nurse practitioners who geographically are located in North Mississippi.

General alternative therapies - health care approaches not ordered by nurse practitioners that are outlined in section A of the Barrett Folk Alternative Health Information Survey.

Herbs - substances that are not prescribed by a conventional medical doctor, as measured by the items outlined in section B of the Barrett Folk Alternative Health Information Survey.

Taken by mouth - alternative therapies that are taken by the oral route to help maintain wellness or prevent disease as measured by the oral therapies outlined in section C of the Barrett Folk Alternative Health Information Survey.

Applied to your skin - alternative therapies that are applied topically to help maintain wellness or prevent disease as measured by the skin therapies outlined in section D of the Barrett Folk Alternative Health Information Survey.
**Spiritual/religious** - alternative therapies that are divine or inspired to help maintain wellness or prevent disease as measured by the spiritual items outlined in section E of the Barrett Folk Alternative Health Information Survey.
Chapter II

Review of Literature

Review of the current literature focused on the use of alternative therapies by patients in the rural and urban settings. The review of literature revealed many aspects of alternative health care practices. Folk medicine, alternative health care practices using herbal remedies, religious or spiritual practices, remedies taken by mouth and applied topically will be the focus of this review of the literature. The literature review identified alternative health care practices among patients in both rural and urban settings. The majority of the literature reviewed pertained to patients who visited physicians. No research was identified concerning alternative health practices of patients who visited nurse practitioner clinics or clinics in North Mississippi.

Folk medicine and herbal remedies

Folk medicine is germane to many cultural and ethnic groups. Individuals from all branches of society use some
form of folk medicine alone or in conjunction with conventional medicine in treating or preventing illnesses. The importance of folk medical practices varies among different ethnic and cultural groups dependent upon socio-economic and educational status (Bullough and Bullough, 1982). Many ethnic and cultural groups practice folk medicine because of the healing properties of certain herbs and spices. Folk medicine may also be characterized by a belief in supernatural forces (Giger et al., 1992).

Cook and Baisden (1986) sought to ascertain the prevalence of the practice of folk medicine within the state of West Virginia and what impact the use of folk medicine had on the medical community. Natural folk medicine was defined as the use of non-prescription, non-proprietary herbs, plants, minerals, and animal substances in treatment of common ailments. The use of natural folk medicine was the outcome variable.

Current knowledge and the use of folk remedies were obtained from the survey. The questionnaires were distributed to patients at three rural southwestern West Virginia primary care clinics. A list of 61 popular folk remedies and sociodemographic questions was on the
questionnaire. If an identified remedy was used, further questions were asked which related to the origin of the remedy, effectiveness, symptoms, condition treated, and use of the remedy during the last 12 months (Cook and Baisden, 1986).

A convenience sampling method was used and 170 respondents ranging in age 21 through 87 from urban and rural areas completed the survey. Of the 170 respondents, 124 reported the use of at least one remedy in the past 12 months. Seventy six percent of the folk medicine was used in rural areas verses 70% in urban areas (P = 0.3599 by chi-square analysis). Seventy eight percent of the women and 65% of the men surveyed used remedies (P = 0.1610). There were no significant differences between men and women in the use of folk remedies in rural subpopulation (P = 0.0337). The urban subpopulation demonstrated the use of folk medicine to be lower in men than women. Statistical differences were found between age groups of the users and non-users (P = 0.0014). Ninety six percent of the respondents were less than 35 years of age, compared to 67% of those more than 50 years of age (P = 0.0004). No statistical relationship was revealed between the number of
remedies used per person and the variables of sex, location, and age. Of the 170 respondents, 142 professed knowledge of and had experience with folk remedies which resulted in a cumulative frequency of 957 responses. A cumulative frequency of 553 actual uses of remedies in the last 12 months was reported.

The researchers discovered the use of folk remedies in southwestern West Virginia in both urban and rural areas. Fifteen folk remedies were revealed as the most popular by respondents in southwestern West Virginia. The folk remedies used were salt, baking soda, aloe vera, sweet oil, honey, horehound, peppermint, alcoholic beverages, lemon, vinegar, turpentine, yellow root, catnip, witch hazel, and onions. It is significant to note that 124 respondents were consulting a physician while simultaneously using folk remedies to treat their illnesses. Most respondents reported that they planned to continue their use of folk remedies, but preferred that their families seek professional care. The majority of the folk remedies used in this study might be classified as "benign" (Cook, 1986, p.1101). There were some remedies which were identified as having deleterious effects, such as yellow root, which was used to treat sore
throats. Other patients also reported using catnip, a potent hallucinogen, to treat colic and asthma (Cook and Basiden, 1986).

The use of folk alternative therapies have yet to be determined in the state of Mississippi. The effect of certain folk alternative therapies is known to be potentially harmful to one's health. Folk alternative therapies were germane to this study because health care professionals do not always solicit their patient's practices of alternative therapies. The nurse practitioner should determine the harmful implicatins of certain alternative practices to the patient.

African American folk health beliefs

A ethnographic study by Robinson (1981) explained and described the folk health belief system of black Virginians living in a rural community. In this study, folk was defined as "of the people" and was referred to the peoples' own understanding, ideas, and practices.

A rural county in Virginia was chosen as the locale for the initial pilot study. The snowballing technique was used in the selection of participants. Through this approach, 33
persons were interviewed that lived in the locale, and the local pharmacist was interviewed with questions which pertained to home remedies. Interviews were unstructured, with the exception of an interview guide, which helped assure coverage of the data areas including health maintenance, cause of illness, home remedies, and healers.

The following year Robinison devoted her abilities to full time study of the black culture. Through many contacts from her pilot study, Robinison administered 55 formal interviews in 46 separate households where approximately 138 persons lived. An additional 12 formal interviews were completed with community leaders and health professionals. Data collection was conducted through several research techniques such as formal interviews, informal interviews, participant observation, unobtrusive measures, field notes, and instruments. In addition to the topics in the pilot study, Robinson explored beliefs about blood, childbirth, the health care system, and social stratification. Family members of 23 households were also selected to maintain a three week record of family members' health, any actions taken, source of any health advice, and the results of actions. The majority of the respondents were over 40 years
of age, had less than a 9th grade education, and were predominately of the Baptist religion.

Robinison identified several folk health belief systems of Colonial County, West Virginia blacks. The first belief system she described was the religious belief system. The church was suggested to have influence on values, serve as a source of strength and power, and play a role in social and political change. The role of God, faith, sin, prayer, salvation, the Bible and after-life in relation to health were recurring themes. Health was widely viewed by participants as a gift or blessing from God. In maintaining that health, faith and prayer were of major importance. Several participants believed that true Christians could drink poison and not be hurt.

The use of charms was also noted. The herb asafetida was worn in a bag on a string tied around the neck. The herb would give off an obnoxious odor to ward off evil. Wearing of copper bracelets was used to help prevent arthritis from developing. Another example of a health belief was hanging onions over a door or window to keep germs away.

Dietary patterns were also mentioned as a major factor in maintaining health. The practice of eating non-foods was
common. Pica, or an appetite for non-food substance, is a phenomenon which has been persistently reported in the data on several cultural groups (Kiple and King, 1981). Some examples of non-food substances were sand, dirt, baking powder, cornstarch, clay, plaster, baking soda, and ashes. It was also noted in some instances that up to two pounds a day of nonfood substances were consumed.

The utilization of home remedies was noted by all participants in the study. Home remedies encompassed an extensive number of measures. The few herbs that were noted to be harmful were jimson weed, mullein, and poke weed. These were used by a few informants. Topical remedies such as aloe vera, ammonia, perfume, shoe polish, tobacco, lemon extract, butter, Vaseline, baking soda, cobwebs, flour, eggs, tooth paste, and raw potatoes were used for numerous conditions ranging from asthma to scar prevention. A few remedies were thought to have a magical quality such as boric acid and urine for thrush treatment.

Robinison identified five key themes and patterns which affected the health belief system of blacks in Colonial County. The themes were economic, political, educational, religious, and medical. "The unity of the mind, body, and
soul is a key theme which underlies informants' beliefs about health promotion, prevention of sickness, casualty of health problems, and restoration of health" (Robinson, 1983, p.203). Informants of Colonial County combined elements from all parts of the ethnomedical system. They turned to spiritual, physical and psychosocial approaches and resources in resolving health matters.

African Americans comprise a very diverse population in North Mississippi. Until recently, African Americans have not had as much access or opportunity in relation to health care. In some cases the African Americans of the South have been denied health care even when diseases have been identified. One such case was the Tuskskiegee syphilis experiments of the 1930's. When history has revealed that certain populations of people, such as the African Americans, have been denied health care, it is essential for nurse practitioners, through research, to seek and understand what forms of alternative therapies the African American communities are utilizing today. According to Locks and Boateng (1996) African Americans use home remedies first and then consult with modern conventional methods.
Unconventional therapies

A descriptive study conducted by Eisenberg et al. (1993) sought to determine the prevalence, cost, and patterns of use of unconventional medicine in the United States. Unconventional therapies were defined as medical interventions not taught widely in U.S. medical schools or generally available at U.S. hospitals. Examples included acupuncture, chiropractic, and massage therapy. Eisenberg et al. (1993) focused on the following questions: What is the extent of use of unconventional therapies in the United States? What is the cost for unconventional therapies annually, including out of pocket and third party payments? What sociodemographic factors distinguish users of unconventional therapy from non-users? For what medical conditions do people most commonly use unconventional therapy? To what extent are medical doctors responsible for, or informed about, the use of unconventional therapy by their patients?

Eisenber et al. (1993) conducted a descriptive study to determine what types of unconventional therapies were used in the United States. All information obtained was through a three month telephone survey. The sample was selected by
means of random - digit dialing. The prospective sample was limited to English speaking persons who were 18 years of age or older and in whom cognitive or physical impairment did not prevent the completion of the interview. Eisenberg et al. (1993) calculated that 1500 interviews should produce estimated prevalence rates with 95 percent confidence intervals of 2 to 3 percent. Of the 2295 eligible respondents, only 1539 completed the interview. Only one respondent per household was eligible to be interviewed. The person interviewed was selected by computer randomization from the list of household members given by the first household member contacted.

The telephone interview was described as a survey which averaged 25 minutes in length. Investigators first asked respondents about their interactions with medical doctors during the last 12 months. Then the respondents were asked about medical conditions. At this point respondents were asked about unconventional therapies. When respondents reported the use of unconventional therapies, they were also asked whether a "professional" (Eisenberg, D, 1993, p.247) was involved. A professional was defined as someone who provides care or gives advice and is paid for his or her
services. Total charges for each visit and whether insurance paid for any of those charges were assessed (Eisenberg et al., 1993).

One in three respondents (34%) used at least one unconventional therapy and nearly two thirds (64%) of those who used unconventional therapy did so without visiting a provider of unconventional therapy. There were no significant statistical differences according to sex or insurance status and only a small variation according to the size of the community. Age groups from 25 to 49 years of age (38%) were statistically significant. They were more likely to use unconventional therapy than those who were younger (33%) or older (28%) (P<0.05) was used for both comparisons. The use of unconventional therapy was less common statistically among blacks (23%) than members of other racial groups (35%; P<0.05). Persons with some college education (44%) showed statistically significant greater use than those with no college education (27%; P<0.05). The use of unconventional therapy was statistically more common among people with annual incomes above $35,000 (39%) than those among lower incomes (31%; P<0.05). Geographic location indicated unconventional therapy was more common among those
living in the West (44%) than those living in the rest of the country (31%; \( P < 0.05 \)).

The highest frequency of unconventional therapy use was for back problems (36%), anxiety (28%), headaches (27%), chronic pain (26%), and cancer and tumors (26%). The most commonly used unconventional therapies in 1990 were relaxation techniques, chiropractic, and massage therapy. The rates of use of unconventional therapy with those who consulted a medical doctor varied from condition to condition. Nine of 10 respondents (89%) sought providers of unconventional therapy without the recommendation of their medical doctor. The majority of unconventional therapy users did not inform their medical doctors of their use of the therapy (Eisenberg et al., 1993).

The majority of the respondents (55%) paid the entire cost of their visits for unconventional therapies out of pocket. The most common third party payments were for herbal therapies (83%), providers of biofeedback (40%), chiropractors (39%), and providers of megavitamins (30%).

Eisenberg et al. (1993) found that unconventional medicine had an enormous presence in the U.S. health care system. The preceding study revealed an estimated one in
three persons in the U.S. adult population uses unconventional therapies. The results also suggest that the use of unconventional therapy is not limited to the person's principal medical condition. The majority of unconventional therapy consumers in this study did not discuss their alternative therapy with their medical doctor, suggesting a deficiency in patient - doctor relations. Eisenberg et al. stated that a more in-depth and thorough patient history should be performed in relation to alternative therapies.

The current study seeks to identify the use of alternative therapies in order to derive implications for nurse practitioners such as improved patient historical information. Through in-depth history taking, improved patient care can be achieved.

Another study of alternative therapies by Verhoef, Sutherland, and Brkich (1990) evaluated the proportion of patients attending a gastroenterology outpatient clinic who sought alternative medical care for the same health problems that prompted them to see a gastroenterologist. The authors also sought to determine whether there were differences in sociodemographic characteristics, use of health care services, and general health status between patients who use
alternative therapies and those who seek only conventional medical care. The following hypothesis was tested: "patients attending a gastroenterology clinic who use alternative medicine are more likely to have functional disease than non-users, are less satisfied with conventional medicine that non-users, and are more skeptical of conventional medicine than non-users" (Verhoef et al., 1990, p. 122). The authors defined the users of alternative medicine as patients who have seen practitioners of alternative medicine such as chiropractors, naturopaths, herbalists, homeopaths, or some types of nutritionists during the previous two years.

The data gathered for this study was obtained from patients (n = 395) who were referred to the University of Calgary Gastroenterology Outpatient Clinic between May and September 1988. The patients completed a self-administered questionnaire that was provided by a research assistant prior to seeing a gastroenterologist. The questionnaire consisted of sociodemographic characteristics, use of health care services, overall health status, satisfaction with conventional medicine and alternative medicine, and
skepticism toward conventional medicine (Verhoef et al., 1990).

To ascertain the patient's disease process between functional versus organic disease, the gastroenterologist gave a diagnosis and assigned a functional rating from 1 (highly functional disease) to 5 (highly organic disease). The gastroenterologists in this study had a 89% agreement in assigning the functional ratings. Patients' skepticism toward conventional medicine also was measured with a three item index. Each item was coded 1 (agreement) and 2 (disagreement) and from this a score was determined. Total scores could be 3 (very skeptical) to 6 (not skeptical). Patients who used alternative medicine care for conditions other than gastrointestinal disease were excluded from the study.

Comparison of alternative medicine users with non-users was achieved by data analysis with the statistical software packages Statistical Package for the Social Sciences (SPSS) and Biomedical Data Programs (BMDP). Descriptive statistics were calculated. Depending on the level of measurement and the number of cases, chi-square, Fisher's exact method, or the t-test was used to test the correlation between
variables. Discrimination of variables between alternative medicine users and non-users was determined by logistic regression (Verhoef et al., 1990).

Four hundred and twenty nine patients were contacted during the months of this study. A total of 395 patients completed the questionnaire, which revealed 287 (73%) had not used alternative medicine, 72 (18%) used alternative therapy for conditions other than gastrointestinal disease, and 36 (9%) patients did use alternative therapy for conditions related to gastrointestinal disease. Sociodemographic data revealed 60% of the patients were female and the average age of the patients was 43.4, with half of the patients less than 40. The majority of the patients had completed high school (78%), were married (68%), and were employed (68%). Over half of these alternative medicine users (58%) made the decision on their own to use alternative practices, 36% were encouraged by others, and only one patient was encouraged by his regular medical doctor.

Verhoef et al. (1990) found no significant differences between alternative medicine users and non-users in relation to sex, age, martial status, education, employment status,
income, or use of health care services. Alternative medicine users consistently reported poorer health than the non-user. Seventy percent of the alternative medicine users, compared with 47% of the non-users, reported stressful life experiences during the previous year (p<0.02).

Functional ratings 1 and 2 as well as 4 and 5 were combined due to the small numbers. The results revealed patients with functional diseases were more likely to seek alternative medicine care than patients with organic diseases (33% v. 7%) (p<0.0001). The validity of the functional rating was established by cross-tabulating functional rating with diagnosis. This relationship had strong statistical significance (p<0.0001).

Verhoef's study revealed alternative medicine users (54%) were statistically less satisfied than non-users (85%) with conventional medicine (p<0.001). More alternative medicine users (49%) were significantly more skeptical than non-users (13%) of conventional medicine (p<0.0001). Functional ratings and skepticism toward conventional medicine emerged as the best predictor for use of alternative medicine (p values for goodness of fit 0.99 and 0.99 respectively). Lack of satisfaction with conventional
medicine was highly correlated with alternative medicine use. The variables most strongly related to use of alternative medicine were functional rating and skepticism toward conventional medicine (Verhoef et al., 1990).

Verhoef et al. studied alternative therapies in relation to certain disease processes. In Verhoef's study, alternative therapy users consistently reported poorer health compared to the non-alternative therapy users. The current study identified the frequency of use of alternative therapies in nurse practitioner clinics in rural and urban North Mississippi. Health satisfaction and the frequency of alternative therapies were an important part of this research.

Another study by Cassileth et al. (1994) sought to determine the survival length and quality of life among end stage cancer patients treated with conventional therapies verses unproven treatment methods. This study formulated two hypotheses. The first hypothesis is that survival time would not differ between patients treated with conventional therapies compared to patients treated with unproven treatment methods. The second hypothesis was that the quality of life of the patients receiving unproved therapy
would be superior to that of the patients receiving conventional medical therapy.

Patients selected for this study met the following eligibility criteria: documentation of cancer by tissue biopsy, no previous diagnosis of cancer, the absence of brain metastases at enrollment, 21 years or older, and an awareness of their diagnosis and consent for the study. All patients selected for the study had a median estimated survival time of one year or less. Conventionally treated patients were defined as patients who remained under the exclusive care of a conventional oncologist at the University of Pennsylvania. Patients treated with unproven methods were defined as those receiving treatment at the Livingston-Wheeler Clinic. The treatment regime at the Livingston-Wheeler Clinic is based on studies that a variety of cancer tissues revealed the presence of the microorganism identified as Progenitor cryptocides. Treatment regimens aimed at the premise that it was necessary to produce immunity in the host to resist the infectious agent. Injections of bacille Calmette-Guerin, an autogenous immune enhancing vaccine, was given. The treatment regimen also included eliminating all animal products from the diet which
were believed to be a cause of the microorganism, a strict vegetarian diet, 75 percent of it raw, and coffee enemas (Cassileth et al, 1994).

Sample size of this study consisted of conventional treated patients (N=78) and unproven methods (N=78). The researchers reported the study groups appeared to be representative of the large patient populations, free of sampling bias based on the variables for which data was collected. Patients who received conventional or unproven treatment methods were paired and matched according to sex, race, age, diagnoses, and date of metastatic or recurrent diseases. Both matched and unmatched analyses were performed. Relative risks and 95 percent confidence intervals are given, and all P values reflect two-tailed t-test. A total of 78 matched, eligible pairs of patients made up the study sample (Cassileth et al, 1994).

At enrollment of the study and every two months until the patient's death their performance status was indicated according to the criteria of the Eastein Cooperative Oncology Group: "capable of normal activity; symptomatic but ambulatory; bedridden <50 percent of the time; bedridden < 50 percent of the time but not completely; or completely
bedridden" (Cassileth et al., 1994, p. 1182). Also at enrollment and every two months thereafter follow-up quality of life was assessed with the Functional Living Index-Cancer, a 22 item self report scale developed for repeated assessment of cancer patients. The scale provides a single quality of life score based on indexes of perceived physical well being, psychological state, sociability, effect on family members, and nausea. Patients receiving unorthodox therapy received a detailed information form listing autogenous vaccines, vitamins, minerals, enemas, special diets, and other unconventional and conventional therapies with instructions to check the ones they had received since the previous test (Cassileth et al, 1994).

A total of 156 patients were enrolled in the study, ranging in age from 24 to 81 years, with a median age of 59. Sixty six percent of the Livingston-Wheeler patients and 51% of the University of Pennsylvania patients were college graduates. Differences between the two groups of patients were not significant at P< 0.05. Data on performance status indicated that 96% of the University of Pennsylvania and 91% of the Livingston-Wheeler patients were ambulatory as of the last interview (P=0.33) (Cassileth et al, 1994).
Analysis of the data indicates the only difference in survival according to each demographic and clinical characteristics was sex (P=0.04), with women living longer than men (median, 17 verses 14 months). Chemotherapy, radiation therapy, or surgery revealed no statistically significant differences in survival between Livingston-Wheeler and University of Pennsylvania patients (Cassileth et al, 1994).

Performance status identified through variable by variable analysis revealed no significant differences (P=0.9 by the Breslow statistics, 0.7 by the Mantel-Cox statistics, and 0.9 by the Tarone-Ware statistic). Matched analyses were performed for pairs of deceased patients (P=0.6), and survival analyses were conducted for matched patients (P=0.5). The Cox regression model was used to evaluate the following variables: age, sex, income level, performance status, treatment (unorthodox verses conventional), marital status, education, initial Functional Living Index scores, and chemotherapy before and after enrollment. Only sex approached significance (P=0.06; relative risk, 1.39; 95 percent confidence interval, 1.00 to 1.97) (Cassileth et al, 1994).
The second research hypothesis was that quality of life would be better among Livingston-Wheeler patients than among University of Pennsylvania patients. Repeated measure analysis of variance was used to test the hypothesis. The University of Pennsylvania patients had significantly better quality of life at all times ($P=0.002$). The difference in quality of life over time was also significant $P(<0.001)$. There were no interaction effects ($P=0.92$) which demonstrated the quality of life for both groups deteriorated at an equal rate (Cassileth et al, 1994).

Even though the principal finding of this study was that length of survival did not differ in the two groups of patients identifying that the conventional and unproved treatments studied were similar in efficacy. The researcher also proved that as the public and patients become better educated, dissatisfaction with conventional care for cancer has grown. A confirmatory trend ($P<0.05$, one tailed) demonstrates dissatisfaction. Sixty six percent of the Livingston-Wheeler patients and only 51% of the University of Pennsylvania patients had college or graduate degrees (Cassileth et al, 1994).
The study by Cassileth et al. (1994) is germane to this research study. Cassileth identified that users of alternative therapies were dissatisfied to a certain extent with conventional medicine in the cancer population. This study will identify patients' attitudes about health and attitudes about health care providers in North Mississippi.

**Homeopathy**

Kleijen, Knupschild, and Reit (1991) performed an extensive review of clinical trials in humans to establish whether or not there is evidence of the efficacy of homeopathy. Homeopathic medicine was first developed by Samuel Hahnemann from the similiar concept. The similiar concept implies that a diluted agent when undiluted in healthy individuals induces complaints in healthy patients. Homeopathy is highly individualized according to each person's complaints which results in different treatment for different individuals according to Kleijen et al.

Homeopathy clinical trials were only eligible if they contained control groups. Crossover designs were also eligible, but controlled studies in animal models were excluded. Criteria for methodological assessment of the
experiments was established to exclude trials with a lot of bias. Trials with a high number of participants were weighed heavily over those with a fewer number of participants. The researchers also identified that groups with a large number of participants showed higher efficacy associated with homeopathic treatment. Other major criteria for methodological soundness was randomization and double blind studies (Kleijen et al., 1991).

The criteria of this study was based on meta analysis. Assessment of the methodological quality of 107 controlled trials in 96 published reports was used for investigation. All studies under analysis were graded according to seven methodological criteria and then given a score up to a maximum of 100 points. The seven methodological criteria included the following: 1) patient characteristics adequately described 2) number of patients analyzed 3) randomization 4) intervention well described 5) double blindness 6) effect to measurement relevant and well described and 7) presentation of the results in such a manner that the analysis can be checked by the reader. All articles were checked by at least two researchers for errors and scoring criteria. The largest difference between
researchers when comparing trials was 13 points according to the methodological criteria (Kleignen et al., 1991).

Of the 107 controlled trials only 23 had a methodological score above 55 points and 84 controlled trials scored less than 55 points. Classical homeopathy was used in 14 experiments and only one of these scored more than 60 points according to the methodological criteria. In one double blind randomized trial, the researchers gave one and sometimes two of eight chosen drugs to 30 patients with migraine headaches. Thirty patients in a control group received placebo. Patients treated with homeopathy after four months revealed more improved outcomes than the control group. On a 10 cm visual analogue scale the severity changed from 9-1 to 2-9 in the homeopathy group and from 8-4 to 7-8 in the control group. Frequency of migraine attacks showed similar differences. In 58 studies the same single homeopathic treatment was given to patients with comparable conventional diagnosis. Combination treatments of homeopathic therapies were tested in 26 trials and only one trial compared dilutions with potencies (Kleijen et al., 1991).
The researchers concluded that in most trials a positive result indicated that there was a statistically significant difference in the outcomes. Out of the 105 trials, 81 indicated positive results and 24 trials revealed no positive effects of homeopathy, which was compared with placebo groups (Kleijnen et al., 1991).

Many studies of alternative therapies have been published. Alternative therapies have long been a part of many individuals' naturalistic ways of living. Studies such as the one performed by Eisenberg et al. (1993) have demonstrated that alternative therapies are not necessarily isolated to one geographic area.

Cook and Baiden (1986) identified with their inquiry that some individuals choose alternative therapies which have deleterious effects. Verhoef et al. (1990) revealed in their research study that alternative therapy consumers consistently reported more poor health compared to the non-alternative therapy consumers. Nurses must employ previously documented research and develop further research to initiate changes in nursing practice. This research study sought to describe the type, frequency, and
sociodemographics of patients using alternative therapies in nurse practitioner clinics in North Mississippi.
Chapter III

The Method

The purpose of this descriptive study was to describe the type, frequency, and sociodemographics of patients using alternative therapies in nurse practitioner clinics in North Mississippi. The research determined implications for nurse practitioners. This chapter described the research methods used to investigate the variables of interest. The method of data collection, the population, the sample, the setting, and the instrumentation used in the measurement of the variables will be discussed.

Design of the study

A descriptive survey was chosen for this study to explore and describe the frequency of alternative health care practices. In this study there was no manipulation of the variables.

The variables of interest in this study were frequency, types of alternative health care practices, and various sociodemographic characteristics of patients who use
alternative health practices. The controlled and intervening variables were age, literacy, and the ability to speak English.

Research Questions

The researcher formed three questions to be answered during the course of this descriptive study. The questions are as follows:

1. What is the frequency of alternative health care practices for patients who visit nurse practitioner clinics?

2. What types of alternative health care practices are being used by patients who visit nurse practitioner clinics?

3. What are the sociodemographic characteristics of patients who use alternative health care practices?

Limitations

The following limitations were identified for this study:

1. Only patients who utilize nurse practitioner clinics will be included in the study, which may limit generalization.
2. Only patients over 18 who are able to read and write English will be included in the study.

Setting, Population, and Sample

The setting for this study consisted of two locations. One setting for data collection was a rural nurse practitioner clinic in North Mississippi located approximately 10-20 miles from the nearest city. The comparison clinic was in an urban locale, located within the corporate limits of a city which had a population greater than 20,000. This urban clinic was part of a regional medical center.

The target population consisted of literate, English-speaking adults over the age of 18 who sought care at the two designated nurse practitioner clinics in North Mississippi. A convenience sampling was used with patients who met the criteria and agreed to participate in the study. The target sample size was $N = 150$ ($N = 75$ from a rural clinic and $N = 75$ from a urban clinic).

Methods of Data Collection
This section describes the methods of data collection. Attention is focused on instrumentation, techniques, and procedures utilized for collecting and recording the data.

**Instrumentation.** The instrument utilized for collection of data in the study was the Barrett Folk Alternative Health Information Survey (BFAHIS) (Appendix A). The BFAHIS was a researcher designed instrument. The purpose of the BFAHIS was to solicit the most commonly used folk/alternative therapies. The BFAHIS took approximately five to seven minutes to complete and was written on a sixth to eighth grade reading level. The researcher extracted all of the information listed in the BFAHIS from literature reviews. Alternative therapies were also retrieved from various research studies. The researcher attempted to limit all of the folk therapies to those which were identified in studies of the rural South. The researcher sent the BFAHIS to the Center for Addiction and Alternative Medicine Research (CAAMR), located in Minneapolis, Minnesota. A panel of experts reviewed the tool. The panel of experts consisted of six people, two with bachelor degrees, two with a masters degree, one a doctorate in philosophy, and one with a doctorate of medicine. The CAAMR made suggestions to improve
the BFAHIS. Prior to implementation of data collection, the BFAHIS was piloted using 38 family nurse practitioner graduate students. Revisions were made to increase the strength of the survey tool. Since this was a research developed tool and only used one time, no reliability was established; however, the instrument was submitted to a panel of experts to establish face validity.

The first part of the BFAHIS consisted of demographic data which solicited information pertaining to age, race, sex, employment, marital status, education, income level, and health insurance. The survey was then divided into five sections listed A to E. Section A of the BFAHIS consisted of different alternative therapies. Section B consisted of various herbs. Section C consisted of alternative remedies which were "taken by mouth". Section D consisted of remedies which were "applied to your skin". Section E consisted of spiritual or religious practices. Each section had pertinent items related to that section topic. Respondents were directed to circle items in each section which they may have used to treat an illness, or to maintain their health.

The items that follow sections A through E consisted of two questions asking respondents about their health, each
on a ten point 1-10 Likert rating scale. Three response type questions asking respondents about the medical care and medical personnel that attended for them. Finally the survey ends with a qualitative section in which the researcher asks the respondents to list other treatments they have used in maintaining their health not listed in the preceding Barrett Folk Alternative Health Information Survey.

**Procedures.** Approval from the Committee on Use of Human Subjects in Experimentation of Mississippi University for Women was obtained (Appendix B). The designated administrators at the nurse practitioner clinic were contacted and the purpose of the study was explained. Permission was granted and an agreement for rural clinic (Appendix C) and for the urban clinic (Appendix D) was signed by the administrators.

Personal contact was made with potential respondents by the researcher or by research assistants. Each research assistant held a bachelor degree in nursing or higher and were given instructions to properly distribute the surveys. A brief explanation of the research study was communicated to respondents and any questions were answered. The
respondent was then asked to sign a written consent (Appendix E). After written consent was obtained, the respondent was given a copy of the BFAHIS with an envelope. The respondents were instructed to insert the completed BFAHIS in the envelope which had the name of the clinic indicated on the outside of the envelope. The sealed envelopes were returned to the researcher or research assistants. Research results were placed in a box stored at the residence of the researcher. After all data collection was completed, the researcher then proceeded to examine the data. This process was to assure confidentiality for each respondent.

**Data Analysis.**

Data analysis entailed the use of descriptive statistics, including percentages and measures of central tendency. Categorical data was compiled and analyzed utilizing the Chi-square test of independence. A two-tailed t-test was used to determine the greater number of frequencies between the rural and urban clinics. The qualitative question at the end of the BFAHIS was analyzed
using content analysis. The researcher identified common themes used by the respondents.

**Summary.**

In summary, a descriptive research design was utilized to describe the frequency, type, and sociodemographics of patients who use alternative health care practices in North Mississippi nurse practitioner clinics. The research was conducted in order to determine implications for nurse practitioners. The target population sample size was $N = 150$ ($N = 75$ from a rural clinic and $N = 75$ from a urban clinic). The BFAHIS was used to collect data during data collection at the designated nurse practitioner clinics in North Mississippi. Descriptive statistics and content analysis were utilized to analyze the data.
Chapter IV

The Findings

This chapter describes the sample population, the results of the analyzed data, and the additional findings of the current study. The purpose of this study was to describe the frequency, types, and sociodemographics of patients who use alternative health care practices in North Mississippi nurse practitioner clinics. The researcher conducted the research to determine implications for nurse practitioners. A descriptive survey research design was utilized for data analysis, including percentages and measures of central tendency. Categorical data was compiled and analyzed utilizing the Chi-square test of independence. A two-tailed t-test was used to determine the greater number of frequencies between the rural and urban clinics. The qualitative question at the end of the Barrett Folk/Alternative Health Information Survey (BFAHIS) was analyzed using content analysis. The researcher identified common themes used by the respondents.

Description of the Sample

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The convenience sample for this study consisted of patients ranging in ages 18 to 89 years, who were seeking care at a rural and a urban nurse practitioner clinic in Northeast Mississippi. Target population of 150 was not achieved. One hundred thirteen patients participated in this research study. All participants were asked to sign a consent form and complete the BFAHIS. Sixty six of the 113 participants were rural patients and 47 were urban patients. In the rural group there were 59 females (89%) and 7 males (11%). In the urban group there were 17 females (36%) and 30 males (64%) (see Table 1).

Table 1
Personal Characteristics of Patients Seeking Care at Rural and Urban Nurse Practitioner Clinics Related to Age, Sex, Gender, Employment, Marital Status, Education Level, Income, and Health Insurance

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>30-39</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>40-49</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>50-59</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>60-69</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>70-79</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>80-89</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Demographics</td>
<td>Rural</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Female</td>
<td>59</td>
<td>89</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>48</td>
<td>73</td>
</tr>
<tr>
<td>Black</td>
<td>18</td>
<td>27</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>38</td>
<td>58</td>
</tr>
<tr>
<td>Part time</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td>Unemployed</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Unemployed, not seeking</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Marital Status</td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>49</td>
<td>74</td>
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<tr>
<td>Single</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>High School</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>College</td>
<td>53</td>
<td>80</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10,000</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>10,000-20,000</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>20,001-40,000</td>
<td>18</td>
<td>27</td>
</tr>
<tr>
<td>40,001-&amp; above</td>
<td>29</td>
<td>44</td>
</tr>
<tr>
<td>Health Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Covered</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Individual Policy</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Medicare</td>
<td>44</td>
<td>67</td>
</tr>
<tr>
<td>Covered by Emp.</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>14</td>
</tr>
</tbody>
</table>
Results of Data Analysis

Data was analyzed from all of the BFAHIS to obtain the most frequently used alternative health care therapies by patients who were seeking care at both the rural and urban nurse practitioner clinics. Alternative therapies were listed in the order of the most commonly used (see Table 2).

Table 2
The 25 Most Frequently Used Alternative Health Care Therapies According to Category by Patients Who Were Seeking Care at Both the Rural and Urban Nurse Practitioner Clinics

<table>
<thead>
<tr>
<th>Alternative Therapies</th>
<th>n</th>
<th>category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prayer</td>
<td>78</td>
<td>spiritual/religious</td>
</tr>
<tr>
<td>2. Vaseline</td>
<td>51</td>
<td>topical</td>
</tr>
<tr>
<td>3. Aloe Vera</td>
<td>41</td>
<td>topical</td>
</tr>
<tr>
<td>4. Aloe</td>
<td>40</td>
<td>herbs</td>
</tr>
<tr>
<td>5. Honey</td>
<td>40</td>
<td>orals</td>
</tr>
<tr>
<td>6. Chiropractic</td>
<td>34</td>
<td>general alt. ther.</td>
</tr>
<tr>
<td>7. Lemon Juice</td>
<td>31</td>
<td>orals</td>
</tr>
<tr>
<td>8. Megavitamins</td>
<td>27</td>
<td>general alt. ther.</td>
</tr>
<tr>
<td>9. Whiskey</td>
<td>26</td>
<td>orals</td>
</tr>
<tr>
<td>10. Peppermint</td>
<td>22</td>
<td>herbs</td>
</tr>
<tr>
<td>11. Castor Oil</td>
<td>21</td>
<td>orals</td>
</tr>
<tr>
<td>12. Mediation</td>
<td>20</td>
<td>general alt. ther.</td>
</tr>
<tr>
<td>13. Vinegar</td>
<td>19</td>
<td>orals</td>
</tr>
<tr>
<td>14. Garlic Clove</td>
<td>17</td>
<td>herbs</td>
</tr>
<tr>
<td>15. Massage Therapy</td>
<td>15</td>
<td>general alt. ther.</td>
</tr>
<tr>
<td>16. Baking Soda</td>
<td>15</td>
<td>orals</td>
</tr>
<tr>
<td>17. Ginsing</td>
<td>14</td>
<td>herbs</td>
</tr>
<tr>
<td>18. Butter</td>
<td>14</td>
<td>topical</td>
</tr>
</tbody>
</table>
Categorical data from the BFAHIS was divided to identify which area of alternative therapies was used most often. The categories were general alternative therapies, herbs, orals, topicals, and spiritual/religious therapies (See sections A-E of the BFAHIS in appendix A for therapies in each category). Figure 1 demonstrates the categorical areas in which the most common alternative therapies were used by patients from rural and urban nurse practitioner clinics in North Mississippi.

The inferential statistical analysis, a two tailed $t$ test, was utilized to determine if there was a difference in alternative therapy usage between the patients attending rural and urban nurse practitioner clinics. The two-tailed $t$ test yielded information related to significant values on both ends of a sampling distribution. A two-tailed $t$ test
was used because there was no assumption in the usage of alternative therapies between the rural and urban patient groups. The t test can detect differences between the two groups as if there was no bias toward either group. Degrees of freedom were determined by adding the number of participants in the rural group (66) and the urban group (47) minus the number of independent variables (2). With 111 degrees of freedom, the critical value was -1.98 and 1.98. The level of significance was 0.05 or alpha/2 = 0.025. The calculated t was -0.72. Therefore, the usage of alternative therapies between the rural and urban groups was similar. There is not a significant difference in the frequency of alternative therapies for rural nurse practitioner patients and urban nurse practitioner patients in this study. Table 3 shows the mean scores, standard deviations, and the t test of the participants of the BFAHIS.
Figure 1

Categorical Data Listing the Most Common Alternative Therapies Used by Patients from Rural and Urban Nurse Practitioner Clinics in North Mississippi.

![Bar graph showing the number of respondents for various alternative therapies in rural and urban areas.]

Table 3

Comparison of Rural and Urban Nurse Practitioner Patients Using the Two-Tailed t Test Showing Mean Scores and Standard Deviations on the Barrett Folk Alternative Health Information Survey.

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>66</td>
<td>7.59</td>
<td>5.31</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>47</td>
<td>6.81</td>
<td>5.93</td>
<td>-0.72</td>
</tr>
</tbody>
</table>
The chi-square test of independence was utilized to analyze certain demographic data gathered from the convenience sample. This demographic data consisted of sex, race, education, and income. The frequency of use for alternative therapies was divided into two categories which are as follows: low frequency use of alternative therapies was defined as having a frequency of use from 0-10 per person. High frequency use of alternative therapies was defined as having a frequency from 11 and above per person. Table 4 illustrates chi-square analysis in relation to sex. The critical chi-square test statistic for the sex was 3.84. The calculated chi-square test statistic for the sex was 0.14. Since the calculated test statistic was less than the critical value, no level of significance was shown in relation to sex and the frequency of alternative therapies for this study.
Table 4

**Chi-square Analysis in Relation to Sex**

<table>
<thead>
<tr>
<th></th>
<th>Observed</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>26</td>
<td>26.19</td>
</tr>
<tr>
<td>Female</td>
<td>54</td>
<td>53.81</td>
</tr>
<tr>
<td><strong>High Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men High</td>
<td>11</td>
<td>10.81</td>
</tr>
<tr>
<td>Female High</td>
<td>22</td>
<td>22.19</td>
</tr>
</tbody>
</table>

\[ \chi^2(1, N=113)=3.84, P< 0.05 \]

Table 5 illustrates chi-square analysis in relation to education. The critical chi-square value was 5.99. The calculated chi-square test statistic for education was 0.81. Since the calculated test statistic for education was less than the critical value, no level of significance was shown in relation to education and the frequency of alternative therapies for this study. Figure 3 displays the number of respondents with low and high frequencies of alternative therapy usage according to education.
Table 5  
Chi-square Analysis in Relation to Education

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Observed</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>6</td>
<td>6.37</td>
</tr>
<tr>
<td>High School</td>
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</tr>
<tr>
<td>College</td>
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<td>50.97</td>
</tr>
<tr>
<td><strong>High Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>3</td>
<td>2.63</td>
</tr>
<tr>
<td>High School</td>
<td>9</td>
<td>9.34</td>
</tr>
<tr>
<td>College</td>
<td>21</td>
<td>21.03</td>
</tr>
</tbody>
</table>

\[ \chi^2 (1, N=113)=5.99, P<.05 \]

Figure 3  
Number of Respondents in Low and High Categories Who Use Alternative Therapies With Chi-Square Analysis According to Education Level
Table 6 illustrates chi-square analysis in relation to income. The critical chi-square was 7.81. The calculated chi-square test statistic for income was 55.50. Since the calculated test statistic was greater than the critical value, statistical significance was shown in relation to income and the frequency of alternative therapies in this study.

Table 6  
Chi-square Analysis in Relation to Income

<table>
<thead>
<tr>
<th></th>
<th>Observed</th>
<th>Expected</th>
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</thead>
<tbody>
<tr>
<td><strong>Low Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10,000</td>
<td>15</td>
<td>13.45*</td>
</tr>
<tr>
<td>10,001 - 20,000</td>
<td>16</td>
<td>20.53*</td>
</tr>
<tr>
<td>20,001 - 40,000</td>
<td>23</td>
<td>21.95*</td>
</tr>
<tr>
<td>40,001 &amp; above</td>
<td>26</td>
<td>24.07*</td>
</tr>
<tr>
<td><strong>High Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10,000</td>
<td>4</td>
<td>5.55</td>
</tr>
<tr>
<td>10,001 - 20,000</td>
<td>13</td>
<td>8.47*</td>
</tr>
<tr>
<td>20,001 - 40,000</td>
<td>8</td>
<td>9.05*</td>
</tr>
<tr>
<td>40,001 &amp; above</td>
<td>8</td>
<td>9.93*</td>
</tr>
</tbody>
</table>

*X^2(1, N=113) = 3.84, P < .5*
Table 7 illustrates chi-square in relation to race.
The critical chi-square value for race was 3.84. The calculated chi-square test statistic for race was 37.70. Since the calculated test statistic was greater than the critical value, statistical significance was shown in relation to race and the frequency of alternative therapies for this study.

Table 7

<table>
<thead>
<tr>
<th>Chi-square Analysis in Relation to Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td><strong>Low Use</strong></td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td><strong>High Use</strong></td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>White</td>
</tr>
</tbody>
</table>

*X²(1,N=113)=3.84,P<05*
Additional Findings

Two questions on a 10 point Likert scale asked about the respondent's overall health. Eighty seven percent of the urban and 85% of the rural groups reported 8 or above on the Likert scale indicating excellent health. Surveys revealed that 56% of the urban group had visited a physician one or more times in the last year compared to 77% of the rural group. Overall satisfaction of conventional health care was assessed through the survey. Over 87% of the urban and greater than 91% of the rural respondents revealed that they were satisfied with medical people and the care they had received.

A qualitative question at the end of the BFAHIS was analyzed using content analysis. The qualitative question gave respondents an opportunity to add additional alternative therapies that they were using to improve their health. Common themes were identified.

The most common themes that were identified in this research study were exercise and proper diet. Many respondents revealed that exercise was very important to maintain the body's homeostasis. Many respondents wrote that exercise would "rid the body of poisons". Also respondents
felt that eating a proper diet would keep the body from "taking ill," as one respondent wrote. Many respondents revealed they ate foods that were low in fat and ate "lots of vegetables". The respondents felt these types of food would help maintain optimum health.
Chapter V
The Outcomes

This chapter will address the outcomes of the current study and summarize the findings. The conclusions and implications for nursing will be discussed. Recommendations for further research on nursing study will be addressed.

The purpose of this descriptive study sought to describe the type, frequency, and sociodemographics of patients using alternative therapies in nurse practitioner clinics in North Mississippi. The researcher determined implications for nurse practitioners. Leininger's Theory of Cultural Care Diversity and Universality served as the conceptual framework for this study. The research questions for this study were as follows: 1) What are the characteristics of patients who use alternative health care practices? 2) What types of alternative health care practices are being use by patients who attend nurse practitioner clinics? and 3) What is the frequency of
alternative health care practices for patients who visit nurse practitioner clinics?

The sample consisted of 113 patients, ages 18 to 89 years, who were seeking care at a rural and an urban nurse practitioner clinic in Northeast Mississippi. The instrument utilized for collection of data was the Barrett Folk Alternative Health Information Survey (BFAHIS). A t test for independent samples was used for statistical analysis. The chi-square test of independence was utilized to analyze certain demographic data gathered from the convenience sample.

A summary and discussion of the findings of this study are presented in this chapter. The conclusions, implications for nursing, and recommendations which emerged from those findings are discussed also.

**Summary of Findings**

**Demographics of the Sample.** The sample of this study was predominantly white (72%) and between the ages of 30-39 (27%). Sixty four percent of the sample were married and 61% of the sample were college educated. Over half of the sample (51%) maintained full-time employment and 44% of the rural
sample earned over 40,000 dollars per year, while 34% of the urban sample earned between 10 and 20 thousand dollars per year. Forty four percent of the rural respondents were covered only by Medicare and the majority of the urban respondents (40%) were covered through their employer.

**Alternative therapies.** Alternative therapies were identified according to the most commonly used by the patients that attended nurse practitioner clinics in this study. The 25 most frequently used alternative health care therapies used by patients who were seeking care at both the rural and urban nurse practitioner clinics in Northeast Mississippi are listed in order of most frequently used. They were prayer, Vaseline, aloe vera, aloe, honey, chiropractic, lemon juice, megavitamins, whiskey, peppermint, castor oil, mediation, vinegar, garlic clove, massage therapy, baking soda, ginsing, butter, witch hazel, tobacco, tooth paste, sugar, alfalfa, Clorox, and hypnosis.

**Health coverage.** According to this convenience sample, health coverage was not a major factor in the decision to use alternative therapies. Only 3 respondents (5%) of the rural sample and only 5 respondents (11%) of the urban
sample reported not having any health coverage. The other 105 respondents reported some type of health coverage.

**Discussion. Implications for Nursing**

The findings of this research study indicated that alternative therapies use was common among the patients that attend nurse practitioner clinics in rural and urban Northeast Mississippi. The data indicated that the patients who used alternative health care practices were predominately white, with an annual income greater than $40,000.

The results of this study support the findings of Eisenberg et al. (1993) who found that alternative therapy use was less common among blacks. This study only reported 28% of the black respondents using alternative therapies. Eisenberg et al. (1993) also demonstrated that people with some college education showed greater use of alternative therapies than those with no college education. Use was more common among people with annual incomes above $35,000 than those among lower incomes. The results of Eisenberg's study was consistent with the results of this study which found that 61% of the sample were college educated and the
majority (30%) of the respondents earned over $40,000 per year.

This study is also consistent with the study performed by Cook and Basiden (1983) who demonstrated the use of folk remedies in Southwestern West Virginia to be common in both the rural and urban areas. Several alternative therapies in this study were also identified by Cook and Basiden (1983). Common therapies for both studies were baking soda, aloe vera, honey, peppermint, alcoholic beverages, lemon, vinegar, and witch hazel. This study also identified some alternative therapies that have the potential to be harmful. Baking soda ingested in large amounts can cause anemia and various acid base imbalances. Honey has been documented to cause botulism in infants. Alcoholic beverages in excess have been linked with multiple health problems.

Unlike Verhoef et al. (1990) which revealed in their research that alternative therapy users reported consistently poorer health than non users, this study revealed that 87% of the urban and 85% of the rural respondents thought that they were in "excellent health". This study also revealed that 87% of the urban and 91% of the rural respondents were satisfied with the medical
personnel and care they had received. Casseleth et al. (1994) reported that alternative therapy users were unsatisfied with conventional care and the care givers.

Many respondents did reveal through the qualitative question that diet and exercise were very important in maintaining optimum health. One respondent did write that adequate amounts of time spent with family was healthy. No other alternative therapies were identified through the qualitative question.

One observational finding was interesting to note. During data collection it was interesting that when the researcher approached a male respondent who refused to complete the questionnaire all the male respondents in the waiting room would refuse to fill out the questionnaire. Female respondents would complete the questionnaire regardless of the male respondents' actions.

Leininger's Theory of Cultural Care Diversity and Universality was the conceptual framework for this study. The goal of this theory is to provide culturally congruent nursing care in order to improve nursing care for persons of different cultures. Leininger maintains that care is the essence in nursing and that care and culture are
inextricably linked. The outcomes of this research study are congruent with Leininger's theory. Respondents use different therapies to help aid them in wellness and many of these therapies had been passed down for generations in their cultures.

Researchers need to discover and understand meanings and patterns of culture care from different cultures. Understanding the type of alternative health care practices of patients will enable nurses and nurse practitioners to plan culturally based care for clients using alternative health care practices in Northeast Mississippi.

**Recommendations for Further Study**

Based upon the findings of this study, the following recommendations are made:

**Research**

Research recommendations for further study have been identified. A replication of the same study should be performed using a larger, more diverse sample. Conduction of research should include a larger geographical area. Internal consistency should be determined on the BFAHIS to estimate the instrument's reliability for future studies.
Nursing

This research study has identified recommendations for further research in nursing. Conduction of a similar study to assess the knowledge of the health care providers regarding alternative health care practices is recommended. Teaching strategies aimed at educating nurse practitioners about harmful effects of certain alternative health care practices should be stressed. Some examples of harmful effects include honey that causes botulism and baking soda that causes anemia.
References


APPENDIX A

BARRETT FOLK/ALTERNATIVE HEALTH INFORMATION SURVEY
Barrett Folk
Alternative
Health Information Survey
First, we would like you to answer a few questions about yourself, to help us describe the people who are taking part in the study.

1) Age_____

2) Sex: male [ ] female [ ]

3) Race: black [ ] white [ ] other [ ]

4) Employed: Full time [ ] Part time [ ] Unemployed [ ] Unemployed, not seeking work [ ]

5) Marital Status: Married [ ] Single [ ] Widowed [ ] Divorced/Separated [ ]

6) Education: circle highest level of education

   Elementary: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4 >4yrs

7) Average yearly income: Please place an "x" by the category closest to your HOUSEHOLD income.

   A. Under 10,000 [ ] B. 10,000 - 20,000 [ ] C. 20,001 - 40,000 [ ] D. 40,001 & above [ ]

8) Health insurance: Please place an "x" next to any of the following your are covered by.

   [ ] Not covered by Insurance [ ] Coverage through my Employer
   [ ] Individual Policy [ ] Medicare
   [ ] Medicaid [ ] Other: ______________

9) Directions: For the next 5 sections, please CIRCLE those items you used within the PAST YEAR to treat an illness or to maintain your health.

A. Please CIRCLE any of the following ALTERNATIVE THERAPIES you have used to treat an illness or maintain your health:

   1) acupuncture 5) homeopathy 9) massage therapy
   2) acupressure 6) hypnosis 10) therapeutic touch
   3) biofeedback 7) imagery therapy 11) reflexology
   4) chiropractic 8) iridology

Other(s): __________________________________________________________
**B. Please CIRCLE those HERBS you have used to treat an illness or used to maintain your health.**

<p>| | | | | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td>13</td>
<td>agrimony</td>
<td>23</td>
<td>balm</td>
<td>33</td>
</tr>
<tr>
<td>14</td>
<td>aloe</td>
<td>24</td>
<td>black cohosh</td>
<td>34</td>
</tr>
<tr>
<td>15</td>
<td>angelica</td>
<td>25</td>
<td>holy thistle</td>
<td>35</td>
</tr>
<tr>
<td>16</td>
<td>anise</td>
<td>26</td>
<td>cayenne pepper</td>
<td>36</td>
</tr>
<tr>
<td>17</td>
<td>bayberry bark</td>
<td>27</td>
<td>catnip</td>
<td>37</td>
</tr>
<tr>
<td>18</td>
<td>goldenseal</td>
<td>28</td>
<td>red raspberry</td>
<td>38</td>
</tr>
<tr>
<td>19</td>
<td>hops</td>
<td>29</td>
<td>garden sage</td>
<td>39</td>
</tr>
<tr>
<td>20</td>
<td>licorice</td>
<td>30</td>
<td>red elm</td>
<td>40</td>
</tr>
<tr>
<td>21</td>
<td>myrrh</td>
<td>31</td>
<td>cranberry fruit</td>
<td>41</td>
</tr>
<tr>
<td>22</td>
<td>peppermint</td>
<td>32</td>
<td>hawthorn berries</td>
<td>42</td>
</tr>
</tbody>
</table>

**C. Please CIRCLE those items you have TAKEN BY MOUTH to treat an illness or to maintain your health:**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tr>
<td>53</td>
<td>black pepper</td>
<td>59</td>
<td>baking soda</td>
<td>65</td>
</tr>
<tr>
<td>54</td>
<td>cinnamon</td>
<td>60</td>
<td>vinegar</td>
<td>66</td>
</tr>
<tr>
<td>55</td>
<td>lemon juice</td>
<td>61</td>
<td>beef liver</td>
<td>67</td>
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<tr>
<td>56</td>
<td>honey</td>
<td>62</td>
<td>beets</td>
<td>68</td>
</tr>
<tr>
<td>57</td>
<td>sugar</td>
<td>63</td>
<td>black molasses</td>
<td>69</td>
</tr>
<tr>
<td>58</td>
<td>alfalfa</td>
<td>64</td>
<td>blackberries</td>
<td>70</td>
</tr>
</tbody>
</table>

**D. Please CIRCLE those items you have APPLIED TO YOUR SKIN to treat an illness or to maintain your health:**

<p>| | | | | |</p>
<table>
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<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>ammonia</td>
<td>81</td>
<td>Vaseline</td>
<td>85</td>
</tr>
<tr>
<td>78</td>
<td>perfume</td>
<td>82</td>
<td>Clorox</td>
<td>86</td>
</tr>
<tr>
<td>79</td>
<td>shoe polish</td>
<td>83</td>
<td>cobweb</td>
<td>87</td>
</tr>
<tr>
<td>80</td>
<td>tobacco</td>
<td>84</td>
<td>gasoline</td>
<td>88</td>
</tr>
</tbody>
</table>
E. Please CIRCLE any of the following SPIRITUAL or RELIGIOUS practices you have used to treat an illness or to maintain your health:

94) prayer   97) wear a penny around your neck   100) copper bracelet
95) mediation   98) religious clothing   101) amulets
96) Tai Chi   99) bracelets of string   102) yoga

10. During the PAST SIX MONTHS, how would you rate your overall health on a scale from one to ten? Please CIRCLE ONE.

very poor health

1 2 3 4 5 6 7 8 9 10
_____ _____ _____ _____ _____ _____ _____ _____ _____

easy health

11. Please rate how you feel today on a scale from one to ten. Please CIRCLE ONE.

very poor

1 2 3 4 5 6 7 8 9 10
_____ _____ _____ _____ _____ _____ _____ _____ _____

easy

12. How frequently do you visit a physician for health care including injury, illness, or prevention and general maintenance? Please CHECK ONE.

[ ] Approximately once a week  [ ] At least once a year
[ ] At least once a month  [ ] Less than once a year
[ ] At least four times a year  [ ] Less than once every five years

13. Have you been satisfied with the medical people you have seen during the PAST YEAR?

[ ] Very satisfied  [ ] Slightly dissatisfied  [ ] Not applicable
[ ] Satisfied  [ ] Dissatisfied
[ ] Slightly satisfied  [ ] Very dissatisfied

14. Have you been satisfied with the medical care you have received during the PAST YEAR?

[ ] Very satisfied  [ ] Slightly dissatisfied  [ ] Not applicable
[ ] Satisfied  [ ] Dissatisfied
[ ] Slightly satisfied  [ ] Very dissatisfied
15. Please list any other information or alternative treatments that you use in maintaining your health. Please write in the space provided.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Fold the survey and place in the envelope and seal for your confidentiality.

Thank you for your time.
APPENDIX B

LETTER OF INSTITUTIONAL APPROVAL
February 26, 1997

Mr. Wesley Barrett  
c/o Graduate Program in Nursing  
Campus

Dear Mr. Barrett:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research with the following stipulations:

Participants should have the survey explained to them in the consent so that it is an informed consent.

I wish you much success in your research.

Sincerely,

Susan Kupisch, Ph.D.  
Vice President  
for Academic Affairs

SK:wr

cc:  Mr. Jim Davidson  
    Dr. Mary Pat Curtis  
    Dr. Rent
APPENDIX C

LETTER OF APPROVAL TO USE FACILITY
February 27, 1997

Judy Stevens, RN, MSN, FNP
Evergreen Clinic
Nettleton, Mississippi 38858

Dear Mrs. Stevens:

I am a graduate student at Mississippi University for Women in Columbus, Mississippi pursuing a Master of Science in Nursing with a specialty as a Family Nurse Practitioner. My expected date of graduation is August, 1997.

The purpose of this letter is to request permission to conduct a portion of my nursing research project at the Evergreen Clinic. My thesis involves a description of the prevalence of use of folk/alternative medicine in rural and urban settings. I am also attempting to describe what folk/alternative medicine are currently being used. I would like to be able to obtain volunteer subjects who are 18 or older from your clinic. A questionnaire type format with a completion time of 5 to 7 minutes will be used to elicit data from participants. Confidentiality will be assured to all participants and consent forms obtained prior to completion of the questionnaire.

I would appreciate your assistance in the implementation of this project. You may contact me at (601) 256-1396 if you have any questions regarding the study. I am available to discuss any issues, problems, or suggestions you may have.

Please sign below if you will grant permission for the implementation of this research. Please return this letter in the provided envelop. Thank you for your cooperation.

Sincerely,

Wesley Barrett

Judy Stevens

Evergreen Clinic
APPENDIX D

LETTER OF APPROVAL TO USE FACILITY
March 14, 1997

Magnolia Regional Health Center
Alcorn Drive
Corinth, Mississippi 38834

Dear Debbie King:

I am a graduate student at Mississippi University for Women in Columbus, Mississippi pursuing a Master of Science in Nursing with a specialty as a Family Nurse Practitioner. My expected date of graduation is August, 1997.

The purpose of this letter is to request permission to conduct a portion of my nursing research project in your department at Magnolia Hospital. My thesis involves a description of the prevalence of use of folk/ alternative medicine in rural and urban settings. I am also attempting to describe what folk/ alternative medicine are currently being used. I would like to be able to obtain volunteer subjects who are 18 or older from your clinic. A questionnaire type format with a completion time of 5 to 7 minutes will be used to elicit data from participants. Confidentiality will be assured to all participants and consent forms obtained prior to completion of the questionnaire.

I would appreciate your assistance in the implementation of this project. You may contact me at (601) 256-1396 if you have any questions regarding the study. I am available to discuss any issues, problems, or suggestions you may have.

Please sign below if you will grant permission for the implementation of this research. Please return this letter in the provided envelope. Thank you for your cooperation.

Sincerely,

[Signature]
Wesley Barrett

[Signature]
Debbie King
APPENDIX E

CONSENT TO PARTICIPATE
Consent to Participate

Dear Participant:

My name is Wesley Barrett. I am a registered nurse and a nurse practitioner student enrolled at Mississippi University for Women. I am conducting a study of the prevalence of alternative therapies in North Mississippi. Please sign below that you agree to fill out the Barrett Folk/Alternative Health Information Survey. There will be no names used in this study. No one will see the survey but me, and I will destroy them after I have analyzed them. All information will be kept confidential and none of the information will be shared with health care personnel at this clinic.

Participation in this study is strictly voluntary. You may refuse to participate at any time. Your health care services will not be affected by participating in this study.

I have read the above information and agree to participate in this study.

__________________________   __________________________
Date                        Signature of Participant

__________________________
Date                        Signature of Researcher