Alternative Health Practices Of Homebound Adults In Northeast Mississippi

Jenny Barnes
Mississippi University for Women

Follow this and additional works at: https://athenacommons.muw.edu/msn-projects

Part of the Nursing Commons

Recommended Citation
https://athenacommons.muw.edu/msn-projects/72

This Thesis is brought to you for free and open access by the MSN Research at ATHENA COMMONS. It has been accepted for inclusion in MSN Research Projects by an authorized administrator of ATHENA COMMONS. For more information, please contact acpowers@muw.edu.
ALTERNATIVE HEALTH PRACTICES OF HOMEBOUND ADULTS
IN NORTHEAST MISSISSIPPI

by

JENNY BARNES

A Thesis
Submitted in partial fulfillment of the requirements
for the Degree of Master of Science in Nursing
in the Division of Nursing
Mississippi University for Women
COLUMBUS, MISSISSIPPI
August, 1998
ALTERNATIVE HEALTH PRACTICES OF HOMEBOUND ADULTS
IN NORTHEAST MISSISSIPPI

by

JENNY BARNES

[Signatures of the committee members]
Abstract

More people are relying on alternative practices and less conventional therapies for a wide variety of problems. Alternative therapies have gained increasing popularity, recognition, and usage in the past decade. Minimal knowledge exists regarding the alternative health care practices of the essentially homebound population who may be more likely to use alternative forms of health care due to the difficulty in leaving home and in following with certain cultural beliefs and practices. The focus of this descriptive study was to describe the alternative health practices of home health clients and how these practices may effect care in the primary care setting. Leininger’s Transcultural Nursing Theory served as the theoretical framework. The research question was as follows: What are the alternative health practices among homebound adults? The various types of alternative therapies used were the variables of interest in this descriptive study. The target population was rural homebound adults ages 21 or older who are currently being served by a home health nurse in rural Northeast Mississippi. A convenience sample design was
utilized with an accessible population of 50. The sample completed the Barrett Folk/Alternative Health Information Survey (Revised). Descriptive statistics including frequencies, distributions, and percentages were used to analyze the data. The findings of the study indicated that alternative health practices were commonly used by homebound adults. The top five alternative therapies were prayer, Vaseline, honey, meditation, and aloe vera. Commonly used alternative health practices among homebound adults were common, inexpensive, household items found in most homes. Nurse practitioners need to promote an open attitude about the use of alternative therapies so they can talk openly to clients who may be using them. The nurse practitioner should routinely assess for the use of alternative therapies so that they can teach safety and possible interactions with other drugs. Recommendations for further research included further studies to determine some of the negative experiences clients have had with alternative therapies and for what diagnosis the client used the particular alternative therapy.
Acknowledgments

I would like to thank God for providing a way for me to go back to school and for giving me the strength and the perseverance to complete this program. Without Him, I could not have made it. I have always known that through Him, all things are possible.

I would like to thank my family, friends, and church family for their support and many prayers throughout the year. Especially for their encouragement and for telling me over and over that I could do it.

I would like to thank my parents for raising me to believe that I could do whatever I wanted to if I tried hard enough. They have encouraged and strengthened me throughout the years.

To my sisters and sister-in-laws, and my aunt, who were always there to check on me, keep the kids, and listen to my problems; to my dear friends Janet, Nancy, Debbie, and Cindy who have always supported me no matter what I chose to do; and to P. K. who helped me with my research and gave me encouragement - I say thank you and I love you.

I would like to thank my committee chair, Lorraine Hamm for her leadership throughout the year and to Patsy Smyth and Dr. Linda Cox for their help and guidance on my thesis.
To my precious children who made it on their own sometimes, I say thank you. To Meg who did all the cleaning and some of the cooking, and to John Bryan for the hugs and neck massages while I typed - I love you dearly.

Last, but certainly not least, I would like to thank Ricky for his unending support and encouragement. Without his love and patience, I could not have made it. He took over our home and gave me the chance to fulfill my dreams. He was father and mother to the children, and did whatever had to be done. He took care of me when I didn’t have time to take care of myself. Thank you, Ricky, I love you.
Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>v</td>
</tr>
<tr>
<td>List of Tables</td>
<td>ix</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>I.  The Research Problem</td>
<td>1</td>
</tr>
<tr>
<td>Significance to Nursing</td>
<td>6</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>9</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>10</td>
</tr>
<tr>
<td>Research Question</td>
<td>11</td>
</tr>
<tr>
<td>Assumptions</td>
<td>11</td>
</tr>
<tr>
<td>Terms to be Defined</td>
<td>12</td>
</tr>
<tr>
<td>II. Review of the Literature</td>
<td>13</td>
</tr>
<tr>
<td>III. The Method</td>
<td>34</td>
</tr>
<tr>
<td>Design of the Study</td>
<td>34</td>
</tr>
<tr>
<td>Summary</td>
<td>37</td>
</tr>
<tr>
<td>IV. Presentation and Analysis of Data</td>
<td>39</td>
</tr>
<tr>
<td>Characteristics of the Sample</td>
<td>39</td>
</tr>
<tr>
<td>Findings Related to the</td>
<td>41</td>
</tr>
<tr>
<td>Research Questions</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>52</td>
</tr>
</tbody>
</table>
V. The Outcomes 53

Summary and Discussion of Findings 54
Conclusions 60
Limitations of the Study 61
Implications of Nursing 62
Recommendations for Further Study 64

References 66

Appendix

A. Barrett Folk/Alternative Health Information Survey 69

B. Letter of Permission to use the Barrett Folk/Alternative Health Information Survey 76

C. Letter of Institutional Approval 78

D. Consent to Participate in the Study 80
### List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demographic Characteristics of the Sample by Frequency and Percentage</td>
<td>40</td>
</tr>
<tr>
<td>2. Alternative Therapies Used to Treat an Illness or Maintain Health by Frequency and Percentage</td>
<td>42</td>
</tr>
<tr>
<td>3. Herbs Used to Treat an Illness or Used to Maintain Health by Frequency and Percentage</td>
<td>43</td>
</tr>
<tr>
<td>4. Items Taken by Mouth to Treat an Illness or to Maintain Health by Frequency and Percentage</td>
<td>44</td>
</tr>
<tr>
<td>5. Items Applied to the Skin to Treat an Illness or to Maintain Health by Frequency and Percentage</td>
<td>46</td>
</tr>
<tr>
<td>6. Spiritual, Cultural, or Religious Practices Used to Treat an Illness or to Maintain Health by Frequency and Percentage</td>
<td>47</td>
</tr>
<tr>
<td>7. Responses to Question 10, &quot;During the Past Six Months, How Would Your Rate Your Overall Health Rate on a Scale of 1-10?,&quot; by Frequency and Percentage</td>
<td>49</td>
</tr>
<tr>
<td>8. Responses to Question 11, &quot;Rate How You Feel Today on a Scale from 1-10,&quot; by Frequency and Percentage</td>
<td>50</td>
</tr>
</tbody>
</table>
Chapter I

The Research Problem

Alternative therapies have been defined by Gates (1993) as “the adoption and use of unorthodox treatments (those treatments that lie outside established and widely accepted standards used by health-care practitioners)” (p. 43) and by Keegan (1996) as “those health practices that fall outside conventional mainstream health care and include, but are not limited to, herbal medicine, prayer, massage, charms and folk healing” (p. 278). Ullman (1993) stated that more than one in three Americans used some type of alternative therapy and spent $13.7 billion on alternative treatments in 1990.

In 1992, Congress requested the National Institutes of Health (NIH) look into alternative approaches and provided $2 million to explore such modalities. NIH created the Office for the Study of Unconventional Medical Practices to evaluate such therapies as folk remedies, use of herbs, massage therapy, homeopathy, naturopathy, nutritional treatments, acupuncture and other practices that were considered to be unorthodox (Marwick, 1992).
Individuals have used alternative therapies throughout history. However, the extent to which alternative therapies are used is not well documented. More people are trying alternative practices and less conventional therapies for a wide variety of problems. Alternative therapies have gained increasing publicity in the media, therefore increasing in popularity and use in the past decade. Nurse practitioners in the primary care setting must, therefore, understand what alternative therapies their patients are using in order to provide safe, appropriate care. While many patients view alternative treatments as safe, research has demonstrated that some alternative treatments can be fatal when combined with prescription, over-the-counter medications or if taken in incorrect dosages. A recent survey by Eisenberg (1993) revealed that the general public relies on alternative therapies much more than was previously thought.

In response to a growing interest in alternative therapies, the Office of Complementary and Alternative Medicine was established in 1992 and is now part of the National Institutes of Health (Marwick, 1992). According to Jones (1996), patients are taking greater responsibility for their own health care. Another reason for the popularity of alternative therapies may be that such therapies are viewed as less invasive, less technical, and more gentle and natural than conventional therapies. Many alternative
therapies are regarded as more accessible and less costly than visiting a traditional health care provider. Few people rely solely on alternative therapies, but the number of patients who exclusively use modern, conventional therapies exclusively is shrinking (Champion, 1993).

According to Barrett (1997), the most commonly used alternative therapy was chiropractic, followed by megavitamins, meditation, massage therapy and hypnosis. The most common herbs identified by Barrett were aloe, peppermint, garlic clove, ginseng, witch hazel, and alfalfa. The most common items applied to the skin were Vaseline, aloe vera, butter, tobacco, toothpaste, and Clorox. Honey, lemon juice, whiskey, castor oil, vinegar, baking soda, and sugar were the most common items taken by mouth (Barrett, 1997).

According to D’Epiro (1997), the number of patients who are using herbal medicine has grow exponentially. The most commonly used herbs identified by D’Epiro were ginkgo, echinacea, valerian, St. John’s wort, feverfew, chamomile, ephedra, chaparral, and pennyroyal. All of these are herbs taken by mouth, except pennyroyal, which was noted to be beneficial for skin diseases and should be applied only to the skin (D’Epiro, 1997).

Traditionally alternative therapies have not been covered under most health coverage policies; patients must
pay for such therapies from personal funds. Although many alternative therapies are still paid by out-of-pocket expenses, some insurance companies have begun to develop “natural medicine” health plans. The growing trend in insurance companies paying for such interventions reflects the idea that consumers are demanding that insurers cover bills for unconventional treatments. Insurers have considered alternative therapies unproven, therefore insurance companies have been unwilling to pay for such interventions. Insurers are now responding with a more open-minded approach regarding alternative therapies, because insuring alternative therapies attracts new customers and may lower cost of caring for the insured (Lehrman, 1996).

According to Davis et al. (1996), the fastest growing population in the nation is the 65 and older age group. With the majority of the population growing older, many are likely to become homebound. Little research was identified regarding the alternative health care practices in the homebound population. Such patients may be more likely to use alternative therapies for health care because of the difficulty in accessing more orthodox therapies. According to Davis et al. (1996), rural elders tend to depend on their own resources during illness, such as using home remedies.
In a nationwide study researchers found that one in three respondents reported using at least one unconventional or alternative therapy in the past year, however, 72% of the respondents did not inform their health care provider that they had done so (Eisenberg et al., 1993). The findings of the Eisenberg study should prompt primary care providers to inquire about the use of alternative therapies in their patients primary care. Although many health care providers remain skeptical regarding the use of alternative forms of health care, alternatives therapies continue to be popular with consumers (Keegan, 1996). One may extrapolate from the literature that the use of alternative therapies among homebound persons has been widespread for many years, yet there is presently a dearth of research literature identified which supports such a conclusion (Davis et al., 1992).

Americans choose alternative therapies for numerous reasons. Campion (1993) outlined the following reasons: 1) they want to feel better, 2) easy access, 3) invitations to heal are everywhere, 4) the cost is cheaper than seeing a doctor, and 5) many are dissatisfied with the medical establishment. Campion proposed that many Americans fear modern medicine and often do not feel as if they are taken seriously by health care providers. Further, these consumers of health care resent all the pills, tests, and
technology that are so rapidly ordered by health care providers.

Davis et al. (1992) discovered that many patients tend to depend on their own resources at home before seeking formal health care. Many rural patients reported using home remedies prior to seeking medical help from traditional health care providers.

With the overwhelming use and health care dollar expenditures for alternative therapies, practitioners must be cognizant of the fact that alternative therapies are here to stay. Ullman (1993) also stated that there have been no research studies conducted that identified providers of alternative therapies as negligent. Regardless of the beliefs that one holds regarding the use of alternative health care practices, serious thought must recognize such a positive statement. An exploration of unconventional therapy use will provide improved understanding of what types of alternative therapies are being used by rural home bound patients. With an appreciation of what patients may be using, the health care provider can then ask appropriate questions during assessment. The proposed research will seek to determine the use of alternative therapies among a sample of homebound patients.

**Significance to Nursing**
Family nurse practitioners (FNPs) are uniquely positioned to determine the alternative health practices in homebound adults. The FNP should attempt to ascertain the patients’ use of alternative practices when taking a health history. A non-judgmental attitude must be adopted when discussing such matters to avoid alienating the patient. Most Americans withhold information regarding alternative health care practices, perhaps from fear, ridicule or disapproval from their provider (Eisenberg et al., 1993). The FNP must strive to present a nonjudgmental posture, which will encourage an honest discussion of the alternative practices of the patient. In some cultures, home remedies are very commonplace and accepted, therefore, it is important to provide culturally sensitive and meaningful quality care (Roberson, 1987). The FNP should be aware of the impact cultural practices have on the patient.

The FNP should be knowledgeable about the risks and benefits of a variety of alternative therapies commonly used by patients. The FNP also must remain current in the practice of new and developing alternative therapies. Although many alternative therapies may be considered unorthodox to the FNP, keeping an open dialogue with each patient about alternative therapies is of great importance.

Much can be learned regarding the use of alternative therapies through the area of nursing research. FNP’s are
in an excellent position to use a holistic approach to assess the alternative therapies practiced by their patients. Historically patients have trusted the nurse with information that they may not have divulged to their physician for fear of ridicule. The FNP must identify what practices are safe and evaluate those which may cause harm. This can be done by staying abreast of the latest research describing the possible benefits and harmful effects associated with various alternative therapies.

The researcher proposes that homebound patients may be more likely to use an alternative form of health care because of difficulty in leaving home. The FNP should consider that patients, who are unable to leave home, may use alternative therapies out of necessity, which potentially may be detrimental to their health. Some alternative therapies may be toxic when mixed with conventional medicine, whereas, others may be beneficial and have a curative effect. Regardless of the effects, the FNP must know what alternative therapies are being used by home health patients in the primary care setting in order to intervene appropriately.
Theoretical Framework

The theoretical framework for this study was the Leininger Transcultural Nursing Theory (1978). M. M. Leininger’s conceptual framework deals with culture care diversity and universality and is an appropriate framework on which to base the proposed study of alternative health practices of individuals who are basically confined to the home environment. Leininger stated that diverse factors influence patterns of care and health of well being in different cultures. Culture determines personal life or world views that are mediated through language. Leininger also stated that diverse health systems mediate the expression of health. Nursing is one of the health systems that overlaps with folk systems and professional health care systems (Chinn & Kramer, 1995).

According to Chinn & Kramer, (1995) Leininger states that “caring emphasizes healthful, enabling activities of individuals and groups that are based on cultural modes” (p. 184). Caring is a central focus of nursing and health care services. Nurses should link caring with culture and realize that caring is essential to human development, growth, and survival. If effective, caring reflects professional concern, stress alleviation, nurturance, compassion, comfort, and protection.
Since many diverse cultures are present within the home health environment, the FNP can assist homebound patients to safely combine their cultural beliefs with their particular health care practices, which may include alternative practices. According to Leininger, patients have a right to have their health care practices understood through an understanding of their sociocultural backgrounds (Reynolds & Leininger, 1993). When the FNP has an understanding of the sociocultural background of a particular culture, reasonable care can then be provided.

Health behaviors are influenced through such factors as technology, religion, social and kinship lines and patterns, political and legal factors, philosophic beliefs, economic factors, and educational factors (Chinn & Kramer, 1995). This theory will guide the researcher’s interpretation of why individuals, such as homebound patients, choose a particular alternative therapy.

**Statement of the Problem**

More people are turning to alternative practices and less conventional therapies for a wide variety of conditions. Alternative therapies have gained increasing popularity, recognition, and usage in the past decade, therefore, practitioners in the primary care setting must understand what alternative therapies are being used. The
health professional must recognize and understand the alternative practices of the patient so that appropriate interventions can be made to enhance care. Minimal knowledge exists regarding the alternative health care practices of the essentially homebound population and it is unknown whether the homebound patient is more likely to use alternative forms of health care due to the difficulty in leaving home.

Purpose

The purpose of the study was to identify the alternative health practices among homebound adults.

Research Question

The research question used in the study was as follows:

1. What are the alternative health practices among homebound adults?

Assumptions

For the purpose of this study, the following assumptions were made:

1. Homebound adults use alternative therapies.
2. Alternative health practices can be empirically identified and measured.
Terms to be Defined

The terms to be defined for the research study were:

Alternative health practices: Theoretical: Those health practices that fall outside conventional mainstream health care and are not in conformity with the standards of the medical community. These may include but are not limited to, herbal medicine, prayer, massage, charms, and folk healing. Operational: Health practices measured by the Barrett Folk/Alternative Health Information Survey (Revised).

Homebound adults: Theoretical: Homebound is defined by Palmetto Government Benefits Administrators (1997) as the inability to leave the home due to physical limitations. To leave the home would take a considerable and taxing effort, and generally requires the use of supportive devices, special transportation, or the assistance of others. Absences from the home are infrequent, of a short duration, or to receive medical care. Individuals who leave home infrequently requiring the assistance of another person or an assistive device. Operational: Patients in Northeast Mississippi who are 21 years of age or older and are cognitively intact as evidenced by orientation to person, place, and time who are served by a home health agency.
Chapter II

Review of the Literature

A review of the literature revealed studies in which the use of alternative therapies used by consumers and the recommendations by medical professionals were documented. This review of the literature was focused on the use of alternative therapies in the primary care setting, which lent credence to conduction of the current study. To date, the use of alternative therapies among clients with a preexisting medical problem remains limited. By nature, persons who are recipients of home health services are both chronically ill and have functional impairments. Yet they experience the same opportunities for and vulnerabilities to the use of alternative therapies as the general population. At the time this research was conducted, no research studies were discovered in which alternative therapies used by home health clients.

Eisenberg et al. (1993) conducted a national telephone survey to determine the prevalence, costs, and patterns of use of unconventional therapies and to improve the
understanding of the use of unconventional therapy. Using a
descriptive design, the researchers sought to discover: (1) What is the extent of use of unconventional therapy in the
United States? (2) How much is spent annually on these therapies, including out-of-pocket and third party payments?
(3) What sociodemographic factors distinguish users of unconventional therapy? and (4) to what extent are medical
doctors responsible for or informed about the use of unconventional therapy by their patients?

Eisenberg et al. (1993) defined unconventional therapies as medical interventions not taught widely in U.S. medical schools or generally available to U. S. hospitals. Examples included acupuncture, chiropractic, and massage therapy. A "medical doctor" was defined as a doctor of medicine or osteopathy, not a chiropractor or other non-medical health care provider. Criteria for participation included subjects who spoke English, who were 18 years of age or older, and in whom cognitive or physical impairment did not prevent the completion of the interview. The actual sample, selected by means of random-digit dialing, totaled 1,539 participants.

Conduction of the telephone interview began with questions regarding the respondents' health, health worries, days in bed at home or in the hospital, and indicators of functional impairment caused by health problems. The
respondents were then asked about interactions with medical doctors during the previous 12 months and whether they had used any unconventional therapies during that time frame. From among a list of 18 unconventional therapies, respondents were asked a series of questions regarding costs, and effects of the therapies. Data were then weighted to adjust for variations among households to match the sample to the distribution of the U. S. population and were subjected to the SUDAAN software system for statistical analysis.

Eisenberg et al. (1993) identified that the use of unconventional therapy was not confined to any particular segment of the U. S. society, but was instead distributed widely across all sociodemographic groups. The most common users of unconventional therapies were people in the age range of 25 to 49, who had some college education and incomes above $35,000. Among racial groups, African Americans used unconventional therapies significantly less often than any other racial group (p < 0.05). The researchers estimated that approximately 22 million Americans saw a provider of unconventional therapy for a principal medical condition in 1990.

The 10 most common principal medical conditions for which Eisenberg et al.’s (1993) sample sought unconventional therapies were back problems, allergies, arthritis,
insomnia, sprains or strains, headache, high blood pressure, digestive problems, anxiety, and depression. Relaxation techniques, chiropractic, and massage were the unconventional therapies used most often. Almost nine of 10 individuals surveyed saw a provider of unconventional therapy without the recommendation of their medical doctor and most of those did not inform their medical provider of their use of unconventional therapy.

The majority of respondents paid the entire cost of their visits for unconventional therapies out-of-pocket. Further examination of cost issues revealed that approximately $13.7 billion was spent by Americans in visits and purchases for unconventional therapies. Americans spent approximately $11.7 billion for visits to providers of unconventional medicine and spent $1.2 billion and $0.8 billion respectively on the use of commercial diet supplements and over-the-counter megavitamins. Fifty-five percent of the expenditures for unconventional therapies were unreimbursed by third-party payers, 31% was partially reimbursed, and only 14% was totally reimbursed. Seventy percent of all charges to providers of unconventional therapies were paid for out-of-pocket. The mean charge per visit to a provider of unconventional therapy was $27.60 with a mean out-of-pocket payment per visit of $19.39. This
out-of-pocket cost was comparable to the amount of out of pocket expenditures for all hospitalizations in 1990.

Eisenberg et al. (1993) further established that third-party payment was most common for the services of herbal therapists, providers of biofeedback, chiropractors, and providers of megavitamins. Overall, the estimated number of ambulatory visits to providers of nonconventional therapy in 1990 was 425 million. This number exceeds the estimated 388 million visits in 1990 to all primary care physicians and family practitioners, pediatricians, and specialists in internal medicine combined.

Eisenberg et al. (1993) recommended that healthcare providers should ask the patients about the use of unconventional therapy whenever a health history is obtained. An exploration of the use of unconventional therapy and enhanced understanding of alternative practices were asserted to improve communication about alternative therapies between patients and medical providers in clinical practice (Eisenberg et al., 1993). The Eisenberg et al. research is similar to the current study because both investigations sought to determine the use of alternative interventions among a sample of health care consumers. While smaller than the Eisenberg study, this current study was focused on a homebound population with fewer resources for seeking primary health care. Additionally, the current
researcher sought to examine the use of a larger variety of alternative therapies, rather than the 18 in the Eisenberg research. Data for the current study were collected by health care providers, meeting the Eisenberg et al. recommendations that providers assess client use of alternative interventions.

In the interest of examining a cultural sample, Keegan (1996) also utilized a descriptive survey design to describe alternative therapies used among Mexican Americans in the Texas Rio Grande Valley. The following three research questions were used to guide the study: (1) What specific kinds of alternative therapies do Mexicans in the Rio Grande Valley use? (2) What percentage of the sample group uses alternative therapies? and (3) Do the users of alternative therapies self-report these visits to their established, conventional, primary health care provider?

Keegan (1996) described alternative therapies as “those health practices that fall outside conventional mainstream health care and include, but are not limited to, herbal medicine, prayer, massage, charms, and folk healing” (Keegan, p. 278). For the purposes of the study the term unconventional therapies was used interchangeably with alternative therapies. Folk medicine was defined as “a lay person’s use of household and traditional remedies for maladies and ills” (Keegan, p. 278). Mexican Americans were
defined as "persons of Mexican descent residing on the United States side of the U.S.-Mexican border" (Keegan, p. 278).

Leininger’s Theory of Transcultural Caring served as the theoretical framework for the study. Leininger’s goal is to provide culturally congruent care so that client’s feel satisfied when they receive care.

Keegan (1996) selected a convient sample of patients and visitors from two medical facilities in the geographical area of the Rio Grande Valley. A final sample of two hundred thirteen participants was selected. Participants ranged in age from 18 to 93 years with a mean of 43 years. Gender distribution was fairly equal with 111 females and 102 male participants.

A one-page bilingual English/Spanish written survey form was developed to glean pertinent information from the subjects. Additionally, all research assistants were bilingual. The subjects either completed the form themselves or the form was completed by the research assistant in an interview fashion. Subjects were asked about the number of times they had used 13 specific therapies during the past year. Therapies inquired about included herbal medicine, prayer/spiritual healing, massage, relaxation techniques, chiropractic, curandero,
megavitamins, imagery, energy healing, acupuncture, biofeedback, hypnosis, and homeopathy.

Data analysis by frequency distribution revealed that the most commonly used alternative therapies were herbal medicine (44.1%), prayer/spiritual healing (29.5%), massage (28.3%), relaxation (22.5%), and chiropractic (19.0%). Ninety-four participants reported having used some variety of herbal therapy one time or more during the past year. Sixty participants reported using a sobadores (masseur) once or more during the year. Twenty-nine of the participants visited a curandero (folk healer) during the past year. In response to the question, “How often do you discuss the use of alternative therapy with your health care provider?” 66.1% said they never discussed it, 25.6% said they sometimes discussed it, and only 8.1% said they always discussed their use of alternative therapies. Among participants with whom the interview format was used, nearly every participant expressed beliefs about the beneficial effects of alternative therapy.

Keegan (1996) noted the significance of 66% of the participants never having discussed their use of alternative therapies with the health care provider, which suggests that many conventional providers are unaware of their patient’s use of alternative therapies. Keegan concluded that the phenomenon could greatly influence the outcome of many
patient's conventional care and suggested that health care providers should be aware of their patient's use of alternative therapies so they can better dialogue with those who seek their care. The researcher further suggested that health care providers integrate questions regarding alternative therapies into the patient's history. A knowledgeable provider is one who is sensitive to cultural issues and is open to conversation allowing clients to discuss what their alternative therapies include. Emphasis should be placed on cross-cultural, competent care.

Recommendations which emerged from the Keegan study were as follows: (1) A study to determine what percentage of the Anglo population in the Rio Grande Valley uses alternative therapies; (2) A qualitative study describing clients' individual experiences with each of the 13 named alternative therapies; (3) An investigation into the impact of alternative practices upon the health or well-being of clients; (4) An exploration into strategies that would make it easier for clients to divulge their use of alternative therapies to their conventional practitioners; (5) A study describing some of the negative experiences clients have had with alternative therapies; (6) An investigative study to determine if alternative therapies delayed visits to conventional practitioners and allowed a treatable disease to progress beyond the stage of easy or effective treatment.
by established, conventional means; (7) An exploratory study to see if there are documented examples of cures using alternative therapies; (8) A survey to see how conventional practitioners in the Rio Grande Valley perceive the usefulness of alternative therapies, and (9) An exploratory study to see if clients have had negative experiences resulting from divulging their alternative therapy usage to conventional practitioners.

While the current researcher did not address any of Keegan's (1996) recommendations specifically, this study expanded on Keegan's work in that a wider variety of alternative therapies was addressed. A different but very specific culture, homebound persons in the rural south, was studied. The subjects disclosure of the alternative therapy used to primary care providers was also assessed.

In an older, but very pertinent study, yet another researcher focused on a particular cultural group. Roberson (1987) conducted an ethnographic study over a one-year period to analyze the health beliefs and behavior of a Black cultural group in rural Virginia. Home remedies, their mode of use, substances used, and the associated beliefs were studied. Intensive interviews and participant observations were carried out in a rural community of 10,000 persons. The formal interviews focused on 46 households whose 138 members had diverse demographic characteristics. Informal
interviews were conducted during chance meetings, drop-in visits, and telephone conversations. Data were also gathered at church services and functions, work-place visits, social functions, meetings, as well as in the community.

Roberson (1987), utilizing qualitative analysis, found some of the most common health problems for which home remedies were used were colds, coughs, sore throats, fever, stomach or intestinal problems, boils, rashes, and aches. Common internal remedies for colds, coughs, sore throat, upset stomach and headaches included teas, onion, sugar and whiskey, lemon and honey, horehound leaf and sugar, and wild cherry bark and sugar. Turpentine, kerosene, coal oil, Vaseline and sugar, castor oil, soda and vinegar, flour water, and some patent medicines were also used as internal remedies. External remedies such as cabbage leaf, raw onion, raw potato, tobacco, and mullein weed were used for such ailments as fever, headache, boils, and swellings. Other external topical remedies such as mutton or beef tallow, lemon extract, perfume, red pepper seed, hot salt bag, oatmeal or burned flour, membrane of egg, and fatback were used to treat chest colds, toothaches, rashes, boils, and splinters.

Roberson (1987) also determined that home remedies were often used for emergency situations. People often relied on
their own resources in emergency conditions due to unavailability of health care for rural, Black Virginians. Some of the emergency situations listed were burns, bites and stings, cuts, punctures, nosebleeds, and sprains. Some of the remedies for emergencies were aloe vera for burns; baking soda, butter, sulfur, cobwebs, and Vaseline for burns and cuts; bleach, ammonia or kerosene for cuts, stings and bites; and fatback poultice, honey, linseed oil, milk, potato, salt, soot ashes or tobacco for cuts, stings and burns. Alcohol, peroxide or iodine, hanging cold keys down the back, and putting brown paper under upper lip were used for nosebleeds. Burning the nail, which caused the puncture, was used for nail puncture wounds.

The participants also treated common chronic illness with home remedies. For bladder and kidney problems Jerusalem oak was used; high blood pressure was treated with oak leaves; low blood and "sugar" was treated with peach branch or leaves; and "sugar" alone was treated with wild cherry bark.

Health promotion and illness prevention were also areas in which home remedies were used. Various teas, such as sassafras, or cod liver oil were used to help ward off colds and rid the body of impurities built up over the winter months. Various substances such as garlic, asafetida,
silver, and copper were often worn on the body to ward off sickness.

Roberson (1987) also discussed other alternative therapies participants used to help meet health needs. Approaches embraced by many participants included naturopathy, homeopathy, acupuncture, and naprapathy. The availability and choice of a particular health approach depended upon cultural norms and values of the group.

Research participants expressed concern regarding the side effects of prescribed drugs and the possibility that the side effects could often be worse than the symptoms they were intended to alleviate. Roberson (1987) concluded that nurses working in the community setting need to be cognizant regarding the various health cultures and alternative therapies used by individuals in the community. The nurse also must be knowledgeable concerning individual beliefs and practices and consider the role of the family in health maintenance.

The researchers recommended that nurses should treat patients as holistic beings, and should incorporate physical, psychosocial, and spiritual elements of personhood into assessments and interventions. Such holistic care may also include cultural and home remedies. Nurses must also consider that many patients believe home remedies to be more beneficial and less harmful than drugs. The Roberson study
was a landmark in alternative therapy research and was
germene to current research by providing valuable
information regarding health practices in a community
setting. Many nurse practitioners practice in a primary
care setting, therefore, it is of vital importance to
understand the alternative therapies and home remedies
practiced within a given community, setting, or culture.
Roberson’s (1987) attention to cultural issues and use of
Leininger’s model provided a solid foundation on which to
build this current study. In this study the alternative
health practices of community based homebound persons were
examined.

In addition to cultural considerations, research has
been conducted regarding the use of alternative therapies
among persons with chronic illnesses. Fawcett, Sidney,
Lawless, & Hanson (1996) conducted an exploratory survey
among people with multiple sclerosis (MS). The researchers
sought to determine the association of alternative therapies
with functional status in a group of individuals with the
diagnosis of MS. The study was guided by the Roy Adaptation
Model of Nursing, which depicts people as biopsychosocial
beings who adapt to environmental stimuli.

The investigators recruited 16 respondents from
membership in a national MS society using the snowball
sampling technique. The sample consisted of 12 women and 4
men ranging in age from 32 to 65 years of age. The respondents resided in 10 different states. Telephone interviews were conducted with all of the respondents using the Background Data Sheet (BDS) and the Multiple Sclerosis Alternative Therapies Questionnaire (MS-AT) as a semi-structured interview guide. The MS-AT was composed of open-ended questions which asked participants about the use of alternative therapies and the experiences with such therapies. All of the telephone interviews took approximately an hour and were tape-recorded with the permission of the respondents. The Inventory of Functional Status-Multiple Sclerosis (IFM-MS) was mailed to all respondents who participated in the telephone interview.

The term alternative therapies was not defined in the course of the interview so as to “avoid imparting the investigators’ current understanding of the range of such treatments” (Fawcett, et al., 1996, p. 117). The researcher determined that all of the 16 respondents reported using some form of traditional treatment and at least one additional kind of therapy since being diagnosed with MS. The most common kinds of alternative therapies used by the respondents were dental therapy, homeopathy, massage, nutrition, acupuncture, physical therapy, psychological counseling, aquatic therapy, shiatsu, biofeedback, chelation, therapeutic touch, and yoga. The most frequently
used alternative therapies were physical therapy (44%), nutrition therapy (38%), massage (38%), and psychological counseling (38%). Almost one third (31%) of the respondents used homeopathy, acupuncture, or dental therapy. Most respondents used a combination of at least two alternative therapies.

Types of symptoms for which alternative therapies were sought included numbness, weakness, visual disturbances, paresis, sensory changes, loss of balance, paralysis, bladder dysfunction, fatigue, tremor, tingling, and verbal dysfunction. The most common symptoms were numbness (56%) and weakness (44%).

The respondents were asked to rate their current functional status including activities of daily living and occupational activities. The researchers found that the greater the number of alternative therapies used, the milder the MS symptoms, and the more improved functional status of the MS sufferer. All respondents reported the severity of symptoms decreased as a result of the focal stimulus of year alternative therapies. Fawcett et al. (1996) reported that there was a statistically significant improvement in symptom severity following use of alternative therapies (paired t (15) = 6.45, p. < .0005).

In addition to the statistical findings, three major themes emerged from the content analysis of the qualitative
findings of the Fawcett et al. (1996) study. The first theme was the beneficial effects of specific therapies; the second theme emphasized pacing oneself; and the third was a change in perception of self and a focus on the spiritual aspect of self.

In the content analysis of the responses to the MS-AT, 87% (n=14) of the respondents reported that their expectation of medical care had changed since being diagnosed with MS. Most of the respondents (86%) indicated that they realized that traditional medicine has limits. Fifty six percent reported that they would seek an alternative practitioner sooner if they could begin again.

Fawcett et al. (1996) concluded that a moderate correlation exists between the number of alternative therapies and functional status and the improvement in symptom severity following the use of alternative therapies in MS patients. The researchers suggested that people with MS continue to search for alternative therapies that relieve their symptoms and improve their quality of life. The researchers concluded that while the relief experienced by the MS patients could not be proven to represent a real or placebo effect, most MS patients appear to benefit from a combination of alternative therapies.

Fawcett et al. (1996) recommended that further studies be done using a large heterogeneous sample with
consideration given to purposive sampling to determine the
direct effect of specific alternative therapies on
functional status. While neither purposeful sampling nor
causation were part of the current study, a larger sample
size of chronically ill persons with functional impairments
was used in the current study. The continued investigation
of alternative therapy use among populations of persons with
preexisting medical problems is an important first step in
determining the usefulness of such therapies in conventional
medical and nurse practitioner practice.

In a descriptive study upon which the current research
was based, Barrett (1997) sought to determine the
alternative health care practices of patients who were
clients in nurse practitioner clinics in North Mississippi.
Barrett’s variables of interest in study included frequency,
types of alternative health care practices, and
sociodemographic characteristics of patients who use
alternative health practices. The controlled and
intervening variables were age, literacy, and the ability to
speak English.

Barrett (1997) formulated three questions, using
Leininger’s Transcultural Nursing Theory as a framework, to
be answered during the study: (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? and (3) What are the sociodemographic characteristics of patients who use alternative health care practices?

The setting for the study was two clinics which were operated by nurse practitioners (NPs) and at which NPs were the primary care provider. One clinic was in a rural setting and the other was an urban clinic that was part of a regional medical center. The target population consisted of literate, English speaking adults 18 years of age or older who sought care at one of the two clinics. A convenience sample of \( N = 113 \) was used. The sample consisted of patients utilizing the clinics who met the criteria and agreed to participate in the study.

The instrumentation used for data collection was the Barrett Folk/Alternative Health Information Survey (BFAHIS). Categorical data was compiled and analyzed utilizing the Chi-square test of independence. One qualitative question was analyzed using content analysis for common themes.

The respondents ages ranged from 18 to 89 years. In the rural clinic, 11\% of the respondents were male and 89\% were female, whereas in the urban clinic 64\% were male and 36\% were female. The majority of the respondents were White (71\%), working full-time (50\%), and had an annual income of $40,000 (30\%). Additionally participants were married
Barrett (1997) discovered that the five most commonly used alternative therapies were chiropractic, megavitamins, meditation, massage therapy, and hypnosis. The most common herbs used to treat an illness or to maintain health were aloe, peppermint, garlic clove, ginseng, witch hazel, and alfalfa. The most common items applied to the skin were Vaseline, aloe vera, butter, tobacco, toothpaste, and Clorox. Honey, lemon juice, whiskey, castor oil, vinegar, baking soda, and sugar were the most common items taken by mouth. The most common spiritual, cultural, or religious practice was prayer.

The findings of the study were consistent with findings in studies reviewed in the literature. The researcher recommended replicating the current study using a larger, more diverse sample that would include a larger geographical area. Conduction of a similar study to assess the knowledge of health care providers regarding alternative health care practices was also recommended. A further recommendation made by the researcher was to determine internal consistency on the BFAHIS to estimate the instrument’s reliability for future studies. The researcher stressed the need to educate nurse practitioners about alternative therapies as well as
the possible harmful effects that can occur with certain alternative therapies.
Chapter III

The Method

The purpose of this descriptive study was to identify the alternative health practices among homebound adults. This chapter will describe the research methods used to investigate the variables of interest. The method of data collection, the population, the sample, the setting, and the instrumentation will be discussed.

Design of the Study

A descriptive research approach was utilized for this study. Polit & Hungler (1995) define descriptive research as a study that has as its objective the accurate portrayal of the characteristics of individuals, situations, or groups and the frequency with which certain phenomena occur. Little is known about the use of alternative therapy practices in homebound adults, therefore a descriptive research design is considered appropriate. The various types of alternative therapies used were the variables of interest in this descriptive study.
The settings for this study were the homes of clients who received home health services from a hospital based home health agency in Northeast Mississippi. The target population was rural homebound adults ages 21 or older who were cognitively intact as evidenced by orientation to person, place, and time. The agency had 14 branch offices which served 17 counties throughout Northeast Mississippi. The accessible population for this study included all the clients of the agency who were over 21 years of age. The specific client census varied; but at the time of the study it averaged 1,927. Of the 1,927 clients, 440 lived in an urban area, whereas, the remainder lived in rural areas. Ninety-two percent of the clients were covered by Medicare, 6% were covered by Medicaid, 1.5% were covered by private insurance, and 0.5% were charity or self-pay clients. The majority of the clients were social security dependent. The top diagnoses for the agency, at the time of the study, were CHF, CVA, hypertension, pneumonia, fractured neck of femur, COPD, lung cancer, UTI, and open wounds. A convenience sampling design was utilized for an accessible population of 100.

Protection of the rights of human subjects was regarded by obtaining approval of this study by the Mississippi University for Women Committee on the Use of Human Subjects in Experimentation. Telephone permission was obtained from
North Mississippi Medical Center (NMMC) Research Committee and by the director of the (NMMC) Home Health Agency. The Branch Managers and staff nurses of participating home health offices received appropriate explanation and a briefing as to the purposes and methods of this study. The staff nurses received directions as to appropriate completion of consent forms and the administration of the data collection tool. Home health nurses obtained informed consent (Appendix D) and administered the survey on a routine home health skilled nursing visit to qualifying patient’s. The surveys were collected over a period of 4 weeks and returned to the researcher via courier.

The instrumentation for this study was the Barrett Folk/Alternative Health Information Survey (Revised) (Appendix A). Written permission was granted from the author to revise the tool (Appendix B). The survey consisted of 8 demographic nominal data items including age, sex, race, county, marital status, education, yearly income, and health insurance data. The survey contained 5 sections regarding the respondents’ use of alternative therapies used to treat an illness or maintain health. Section I consisted of eleven items related to alternative therapies. Section II consisted of 42 items that may have been used to treat an illness or to maintain health. Section III consisted of 31 items that have been applied to the skin or to treat an
illness or maintain health. Section IV consisted of 32 items that have been taken by mouth to treat an illness or maintain health. Section V consisted of 12 items related to spiritual, cultural or religious practices used to treat an illness or maintain health. Additionally, the Barrett Folk/Alternative Health Information Survey (Revised) included 4 questions asking the respondent to rate overall health and health care and with a space for the respondent to write in other information pertaining to alternative health practices. The Barrett Folk/Alternative Health Information Survey was used in a previous study (Barrett, 1997) and was considered to have only face validity. Descriptive statistics including frequencies, distributions, and percentages were used to analyze the data. Content analysis was used to identify emerging themes from responses to item numbers.

Summary

In summary, a descriptive research design was utilized to describe the sociodemographics and alternative health practices of home health patients who use alternative therapies in North Mississippi. The research was conducted to identify the alternative health practices among homebound adults. The setting, sample, and population for the study were defined, and the methods of data collection and
analysis were related. A convenience sample design was utilized with an accessible population of 100. The sample completed the Barrett Folk/Alternative Health Information Survey (Revised). Descriptive statistics including frequencies, distributions, and percentages were used to analyze the data. In the subsequent chapters, the findings of the study are revealed, and the implications of those findings are discussed.
The purpose of this study was to identify the alternative health practices among homebound adults. A descriptive correlational study was conducted among clients who received services from a hospital based home health agency in Northeast Mississippi. The research sample was composed of 68 homebound clients 21 years of age and older. Data for the study were obtained using surveys which were distributed and collected by the home health agency’s registered nurses. The Barrett Folk/Alternative Health Information Survey (Revised) was utilized for data collection.

The data collected and analyzed for the study are presented in this chapter. Characteristics of the participants are described first followed by the results of data analysis related to the research questions.

Characteristics of the Sample

The sample for this study was comprised of 68 homebound adults who were currently being served by a home
health agency. Descriptive information regarding
demographic characteristics of the sample is depicted in
Table 1.

Table 1
Demographic Characteristics of the Sample by Frequency and Percentage

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 - 39</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>40 - 54</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>55 - 69</td>
<td>12</td>
<td>16.6</td>
</tr>
<tr>
<td>70 - 84</td>
<td>33</td>
<td>50.7</td>
</tr>
<tr>
<td>85 -100</td>
<td>20</td>
<td>28.4</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>23.5</td>
</tr>
<tr>
<td>Female</td>
<td>50</td>
<td>73.5</td>
</tr>
<tr>
<td>unreported</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>11</td>
<td>15.2</td>
</tr>
<tr>
<td>White</td>
<td>57</td>
<td>84.8</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>19</td>
<td>27.9</td>
</tr>
<tr>
<td>Single</td>
<td>11</td>
<td>16.2</td>
</tr>
<tr>
<td>Widowed</td>
<td>35</td>
<td>51.5</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>3</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Education (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>6</td>
<td>8.8</td>
</tr>
<tr>
<td>5-8</td>
<td>18</td>
<td>26.4</td>
</tr>
<tr>
<td>9-12</td>
<td>33</td>
<td>48.6</td>
</tr>
<tr>
<td>13-16</td>
<td>11</td>
<td>16.2</td>
</tr>
<tr>
<td><strong>Average yearly income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10,000</td>
<td>42</td>
<td>61.7</td>
</tr>
<tr>
<td>10,000 - 20,000</td>
<td>15</td>
<td>22.0</td>
</tr>
<tr>
<td>20,001 - 40,000</td>
<td>5</td>
<td>7.0</td>
</tr>
<tr>
<td>40,001 - &amp; above</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>not reported</td>
<td>5</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Note. N = 68
Health insurance coverage

All of the participants indicated that they had at least one type of health insurance. Nine (13.2%) participants revealed that they were covered by an individual policy. Twenty-six (38.2%) indicated that they were covered by Medicaid, and 65 (95.5%) were covered by Medicare. Only 4 (5%) of the participants were being covered through an employer and 11 (16.1%) had more than one type of health insurance.

Findings Related to the Research Question

For this study the research question was as follows: What are the alternative health practices among homebound adults? From among a list of 128 alternative therapies, respondents were asked to choose those items that they had used within the past 2 years to treat an illness or maintain their health. Data from the Barrett Folk/Alternative Health Information Survey (Revised) was divided categorically to identify which alternative therapies were used most often. The categories were general alternative therapies, herbs, items taken by mouth, items applied to the skin, and spiritual, cultural or religious practices. Therapies which were included on the research instrument but not chosen by any participant are not included in the presentation of data.
Alternative Therapies Used to Treat an Illness or Maintain Health

Participants were surveyed regarding specific alternative therapies used to treat an illness or maintain health. The most commonly chosen alternative therapies used to treat an illness or to maintain health can be found in Table 2.

Table 2
Alternative Therapies Used to Treat an Illness or Maintain Health by Frequency and Percentage

<table>
<thead>
<tr>
<th>Alternative Therapy</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Imagery Therapy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Therapeutic Touch</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Reflexology</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Respondents were asked to select as many therapies as applied.

Herbs Used to Treat an Illness or Used to Maintain Health

Participants were surveyed regarding the most commonly used herbs used to treat an illness or to maintain health. The most commonly chosen herbs use to
treat an illness or to maintain health are listed in Table 3.

Table 3

Herbs Used to Treat an Illness or Used to Maintain Health by Frequency and Percentage

<table>
<thead>
<tr>
<th>Herbs</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aloe</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Peppermint</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Cranberry Fruit</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>Garlic Clove</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Sassafras</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Pepper</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Cabbage Leaves</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Witch Hazel</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Cayenne Pepper</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Garden Sage</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ginkgo Biloba</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ginger Root</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Ginseng</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Catnip</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>St. John’s Wort</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Echinacea</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Respondents were asked to select as many therapies as applied.
Items Taken by Mouth to Treat an Illness or to Maintain Health

The most commonly used items taken by mouth to treat an illness or to maintain health were assessed. Those most commonly chosen by the participants can be seen in Table 4.

Table 4
Items Taken by Mouth to Treat an Illness or to Maintain Health by Frequency and Percentage

<table>
<thead>
<tr>
<th>Taken by Mouth</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honey</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td>Lemon Juice</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Baking Soda</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Vinegar</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Salt</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Potatoes</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Sugar</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Coca Cola</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Onions</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Flour</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>Castor Oil</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>Rice</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Eggs</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Turpentine</td>
<td>11</td>
<td>16</td>
</tr>
</tbody>
</table>

(table continues)
Table 4 (continued).

<table>
<thead>
<tr>
<th>Taken by Mouth</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Megavitamins</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Black Pepper</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Blackberries</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Whiskey</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Tobacco</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Beets</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Black Molasses</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Snuff</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Beef Liver</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Cinnamon</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Kerosene</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Cod Liver Oil</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Brewer's Yeast</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Melatonin</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Red Clay</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other: written in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epson Salt</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CO Enzyme Q-10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tart Tame Cherry Juice</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Respondents were asked to select as many therapies as applied.

Items Applied to the Skin to Treat an Illness or to Maintain Health

Participants were surveyed regarding the most commonly used items that were applied to the skin to treat
an illness or to maintain health. The items that were most commonly used are listed in Table 5.

**Table 5**

**Items Applied to the Skin to Treat an Illness or to Maintain Health by Frequency and Percentage**

<table>
<thead>
<tr>
<th>Applied to the Skin</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaseline</td>
<td>43</td>
<td>63</td>
</tr>
<tr>
<td>Aloe Vera</td>
<td>22</td>
<td>32</td>
</tr>
<tr>
<td>Butter</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Baking Soda</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Perfume</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Tea Bags</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Potato</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Tobacco</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Fatback</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Tooth Paste</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Turpentine</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Lard</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Milk</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Coal Oil</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Kerosene</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>WD 40</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Magnets</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Raw Onion</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 5 (continued).

<table>
<thead>
<tr>
<th>Applied to the Skin</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ammonia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bleach</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Saliva</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Urine</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ion Water</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cabbage Leaf</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Respondents were asked to select as many therapies as applied.

Spiritual, Cultural, or Religious Practices Used to Treat an Illness or to Maintain Health

The spiritual, cultural, or religious practices used to treat an illness or to maintain health were assessed. The most commonly chosen items can be seen in Table 6.

Table 6

<table>
<thead>
<tr>
<th>Spiritual, Cultural or Religious</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prayer</td>
<td>62</td>
<td>91</td>
</tr>
<tr>
<td>Meditation</td>
<td>24</td>
<td>35</td>
</tr>
<tr>
<td>Copper Bracelet</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

(table continues)
Table 6 (continued).

<table>
<thead>
<tr>
<th>Spiritual, Cultural or Religious</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>bracelets of string</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>religious clothing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>tie cloth on body</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>wearing asafetida</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>other: written in</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>buck eye in pocket</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Respondents were asked to select as many therapies as applied.

Item 10 on the Barrett Folk/Alternative Health Information Survey (Revised) asked respondents to rate their overall health and how they felt on the day of the survey. The number "1" indicated very poor health, while "10" indicate excellent health. Numbers between 1 and 10 indicated where the participants believed they fell on the continuum between very poor and excellent health. The mean rating regarding overall health was 6.7, with a median of 4.5 and a mode of 5, indicating that the majority of the home health clients believed themselves to be only moderately healthy. The range of ratings on the overall health scale was 0-10 with an absolute range of 0-10. Table 7 depicts the respondent's rating of their overall health.
Table 7

Responses to Question 10, "During the Past Six Months, How Would Your Rate Your Overall Health Rate on a Scale of 1-10?," by Frequency and Percentage

<table>
<thead>
<tr>
<th>Rating</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>6</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. N = 68

Item 11 on the Barrett Folk/Alternative Health Information Survey (Revised) asked respondents to rate how they felt on the day of the survey. The number “1” indicated that they felt very poorly, while “10” indicated that they felt excellent. Numbers between “1” and “10” indicated where the participants believed they fell on the continuum between feeling very poor and feeling excellent. The mean rating regarding overall health was 6.7, with a median of 4.5 and a mode of 5, indicating that the majority of the home health clients felt only moderately
well on the day of the survey. The range of ratings on the overall health scale was 0-10 with an absolute range of 0-10. Table 8 indicated the respondent's rating of how they felt on the day of the survey.

Table 8

Responses to Question 11, "Rate How You Feel Today on a Scale from 1-10", by Frequency and Percentage

<table>
<thead>
<tr>
<th>How They Felt</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>56</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

Note. N = 68

Item 12 on the research instrument asked the respondent to indicate how frequently they saw a health care provider. Twenty (29.4%) indicated that they saw a health care provider at least once a month, 32 (47%) indicated at least four times a year, 7 (10.2%) at least once a year, and 8 (11.7%) indicated less than once a
year. It was assumed by the researcher that the respondents did not consider visits by a home health nurse to be a visit to a health care provider.

An additional question on the Barrett Folk/Alternative Health Information Survey (Revised) asked that the respondent indicate whether they had ever withheld information regarding the use of alternative therapies from their health care provider for fear of not being accepted, understood or ridiculed. Sixty-six (97%) responded that they had never withheld information regarding alternative therapies from their health care provider, while only 2 (2.9%) indicated that they had indeed withheld information regarding the use of alternative therapies from their health care provider. One of the respondents stated in writing that she had been ridiculed by her health care provider for the use of alternative therapies.

One open-ended item at the end of the survey stated: “Please list any other information or alternative therapies that you use or have used in maintaining your health.” Only 3 participants responded to the open-ended item. One respondent admitted using “banana peel soaked in alcohol” to maintain health. Another respondent had used a combination of lemon and honey, taken by mouth, to maintain health or treat an illness. One additional
respondent wrote that she used exercise for treating back discomforts.

Summary

The data collated and analyzed for this study have been presented in chapter IV. Data analysis revealed that the participants were largely elderly, with 80% over the age of 70. Additionally, the majority of the respondents were female (73.5%), white (83.8%), and unmarried (71.9%). Respondents generally had a high school education or less (83.9%) and had an annual income of less than $10,000 (61.7%). The top 10 alternative therapies from all categories were as follows: (1) prayer, (2) Vaseline, (3) honey, (4) meditation, (5) aloe vera, (6) lemon juice, (7) baking soda, (8) vinegar, (9) salt, and (10) sugar.
Chapter V

The Outcomes

The purpose of this study was to identify the alternative health practices among homebound adults. Since an increasing number of people are relying on alternative practices and less conventional therapies, it was believed that homebound persons may use more alternative therapies due to their natural inability to leave home. The research question for this study was as follows: What are the alternative health practices among homebound adults? Leininger’s Transcultural Nursing Theory served as the theoretical framework for this study.

The sample consisted of 68 homebound adults ranging in age from 27 to 99 who were currently being served by a home health agency. The Barrett Folk/Alternative Health Information Survey (Revised) was used to elicit information regarding the use of alternative health practices by homebound adults. Participants were interviewed in their home during routine home health visits.
In Chapter V, the outcomes of the study are discussed. The conclusions and implications for nursing are presented. Recommendations were included for future nursing research which evolved from this study.

Summary and Discussion of Findings

The findings of the research study indicated that alternative health practices were commonly used by homebound elders served by a home health agency in rural Northeast Mississippi. A number of similarities and differences regarding demographic variables were discovered between the current study and findings of previous researchers.

Participants in the current study were primarily White (84.8%) with Blacks (16%) representing the remainder of the sample. This finding is reflective of the general population in the geographic location in which the study was conducted. However, the mean age for the current study (65) was markedly different that that of the sample in the Barrett (1997) study (>50) which was conducted in a similar geographic area but among a population of community based rather than homebound health care recipients.

Additionally, the current study differed from the Barrett study, which identified the majority of the respondents to be white (72%), male (64%), with an annual income of $40,000 (64%), and a college education (61%).
The current researcher found the majority of the respondents to be female (73%), with a high-school education or less (83.9%), and with an average yearly income below $10,000 a year (61.7%). The preponderance of the sample was reliant on Medicare (95.5%) and/or Medicaid (38.2%) to cover health care costs.

The differences in the demographic variables between previous studies and the current study may have had an impact on the overall findings, which were different from previous studies. The results of this study are consistent with Ullman’s (1993) findings, which indicated that the use of alternative health practices was becoming enormously popular in the United States. All respondents but one in this study admitted to using at least one type of alternative therapy to improve or maintain health. Eisenberg et al. (1993) estimated that approximately 22 million Americans use some form of alternative therapy.

Alternative therapies used by participants in the current study primarily included remedies that were readily available in the home. The lower income level in the current sample may have influenced the choices, as each of the top 5 choices of the current homebound population are remarkably less expensive than the choices of Eisenberg’s (1993) wealthier sample. The top responses in Eisenberg’s research were chiropractic, megavitamins, meditation,
massage therapy and hypnosis. The top responses in the current study were prayer, Vaseline, honey, meditation, and aloe vera.

Another influencing demographic variable may have been that participants in the current research were homebound. Eisenberg’s (1993) and Keegan’s (1996) samples most often chose an alternative therapy which required the person to visit a provider of alternative therapy. In the current research, only 1 of the top 25 responses required leaving home. This was not an unexpected finding in light of the fact that this researcher’s population was, by definition, homebound. It remains unknown whether the homebound adults would utilize other alternative health practices if they had the opportunity to leave home to seek other therapies.

Roberson’s study (1987) revealed the use of many of the same alternative therapies as did the current research. The particular alternative therapies used in both the current study and the Roberson study were Vaseline, honey, aloe vera, lemon juice, baking soda, vinegar, salt, sugar, onion, turpentine, flour, castor oil, and egg. The high utilization of alternative therapies readily available in the home is consistent with Roberson’s (1987) finding that people tend to rely on their own resources when an emergency arises or health care is otherwise unavailable. Roberson contended that the availability and choice of a particular
health approach depended upon cultural norms and values of
the group.

It should be noted that less conventional therapies
such as acupuncture, hypnosis, Tai Chi, and yoga were not
selected as alternative health practices by any of the
participants in the current study. One can presume that
these alternative health practices were outside the realm of
both awareness and culture of rural North Mississipians.
One participant, who denied the use of any alternative
health practice, stated that “this paper is for people who
use witchcraft or voodoo”. Another participant denied using
alternative therapies, then admitted to using only prayer.
Obviously, the participant did not consider prayer to be an
alternative therapy.

Prayer was the number one alternative therapy chosen
among all participants. Ninety-one percent indicated that
they used prayer as an alternative health intervention, and
other participants who did not consider prayer as
“alternative” still indicated that they prayed regularly.
This is not surprising because rural North Mississippi is
located in the heart of what is commonly known as the Bible
belt. Despite differences in age, income, and mobility,
prayer was also the number one alternative therapy among
Barrett’s (1997) Southeastern United States sample, followed
by Vaseline, aloe vera, aloe and honey. All choices in the
Barrett sample were, therefore, remarkably similar to those in the current sample.

The compilation of these culturally related outcomes supports Leininger's concept that culture determines the personal life and the worldview of an individual. Leininger (1978) maintained that care is the essence of nursing and that care and culture are inextricably linked. The outcomes of this research are congruent with Leininger's theory in that individuals chose alternative health practices depending on their cultural norms and lifeways and that many of the particular practices were handed down from generation to generation. Nurse practitioners need to plan culturally based care for clients using alternative health practices which are both appropriate for, and selected by, the clients for whom they are used.

In addition to the demographic and cultural issues, consideration was given to the general health of the participants and how they felt on the day data was collected. On a self-rating scale, the vast majority of homebound adults judged their general health as moderate ($\bar{x} = 6.7$), as well as reporting that they felt moderately well ($\bar{x} = 6.8$) at the time the question was asked. In similar data among multiple sclerosis (MS) patients, Fawcett et al. (1996) discovered that there was a direct correlation between the number of alternative therapies used and
perceived wellness in MS sufferers. While no correlation was empirically assessed, the current researcher noted that the homebound adults who perceived themselves to be more well were the ones who tended to use more therapeutic options. The possible correlation between perceived wellness and use of alternative therapies is fertile ground for further nursing research.

A final important finding indicates that health care providers for the current study's participants were fairly accepting of a client's alternative therapy choices. When the question, "Have you ever withheld information regarding the use of alternative therapies from your health care provider?", was posed, the majority of the respondents (97%) revealed they had not withheld the information. In fact, only two participants had withheld information regarding alternative therapies from health care providers. One of the two stated that she withheld due to previous ridicule and fear of continued ridicule. By contrast, 62% of the participants in the Keegan (1996) study did not share their alternative therapy use with health care providers for fear of non-acceptance, misunderstandings, or ridicule. Such a contrast between the current findings and previous findings may be due to the geographical location of the current study, the home bound status of the participants, or the age of the participants. This researcher proposes that the
acceptance of alternative therapies by health care providers may have increased since the Keegan (1996) study. However, the most plausible explanation is that the benign nature of the alternative therapies used by participants in the current study are unlikely to be disapproved of by health care providers. This finding offers promise for the future of collaborative use of alternative therapies among chronically ill clients and their health care providers.

Conclusions

The findings of this research study indicated that alternative therapies were widely used among homebound adults. The number one alternative practice used was prayer. Commonly used alternative health practices among homebound adults were common, inexpensive, household items found in most homes. It was also concluded that the homebound adults did not use alternative practices that required a visit to a practitioner of alternative therapy. Although the adults surveyed were homebound and were clients of a home health agency, the majority rated themselves as moderately healthy, and reported that they felt moderately well on the day of the survey. Participants did not tend to withhold information regarding use of these therapies from their health care provider. Frequency of visits to a health care provider ranged from once a month to less than once a
year, with the majority of the participants reporting that they see a health care provider at least four times a year. Despite frequent visits to the provider, only one participant reported having been ridiculed by a health care provider for using alternative therapies.

Limitations of the Study

There were a number of constraints upon the study associated with the research instrument chosen. The nature of the instrument did not elicit information regarding the diagnosis or symptom for which the particular alternative therapy was used. The frequency of the use of the therapy was not determined, therefore, the appropriateness of the use of the therapies cannot be assumed. Whether the particular alternative therapy actually worked or was effective was not assessed.

Another limitation may have been associated with the use of research assistants for data collection. While there were a large number of potential research participants, a relatively small sample size emerged. This was determined to have been a result of perceived time constraints placed on the length of the home health visit. The research assistants were nurses who were gathering the data during a regular home health visit and the registered nurses may have
felt that the data collection distracted them from the primary purpose of their visit.

The fact that the participants were homebound and mostly elderly limited the ability of the researcher to generalize the findings to a larger population. Additionally, the accuracy of self-report is always dependent on the participants willingness to reveal personal issues.

Implications for Nursing

This research study was conducted to determine the alternative health practices among homebound adults. Knowledge of the types of alternative therapies used by homebound adults may aide the nurse practitioner in providing a more holistic approach to family practice. Findings from this study have implications for the nursing profession in the area of theory, education, nursing practice, and nursing research.

Nursing theory. Leininger’s Theroy of Cultural Care Diversity and Universality proved to be an appropriate framework for this study. The findings revealed that the particular culture of an individual may influence the use of alternative therapies. Participants used a variety of alternative therapies to aid them in maintaining health and wellness most of which were highly reflective of
Southeastern United States culture and social norms. Therefore, Leininger's model might be appropriate as a framework for additional studies concerning alternative therapies used by other populations.

**Nursing education.** Findings from this study indicate that use of alternative therapies is increasing and that information regarding alternative therapies should be included in curricula of schools of nursing and at undergraduate and graduate levels. As the field expands and nursing seeks to remain a profession which approaches people holistically, the teaching of alternative therapies continues to be a responsibility of the nursing educators.

**Nursing practice.** Nurse practitioners in the primary care setting need to promote and have an open attitude about the use of alternative therapies so they can talk openly to clients who may be using them. Nurse practitioners need to routinely assess for the use of alternative therapies so that they can teach safety and possible interactions with other drugs. Special attention should be given to the possible interactions in regard to common household items that the client may be using to maintain health and wellness.

**Nursing research.** This study sought to determine the alternative health practices among homebound adults. Findings from this study revealed that homebound adults used
a variety of alternative health practices. More research is needed to determine the alternative health practices of various age groups, and of particular cultures and communities. Empirical evidence regarding the outcomes of alternative therapy use among nurses and nurse practitioners also is essential. Publication of nursing research will help nurse practitioners be more aware of the various forms of alternative therapies and for what ailments they are used for.

**Recommendations for Further Study**

Based upon the finding of this study, several recommendations for further study are made. Those recommendations are as follows:

1. Conduction of a study in which both the use and the purpose of the use of alternative health practices are investigated.

2. Conduction of a study describing some of the negative experiences clients have had with alternative therapies.

3. Conduction of a study in which the client’s medical diagnosis is included in the demographic information.

4. Replication of the study with a larger, more diverse sample of non-homebound elders.
5. Conduction of a qualitative study that explores, in-depth, client experiences with alternative therapies.

6. Conduction of a study to explore attitudes and opinions of Health Care Providers about alternative therapies.

7. Conduction of a prospective study to determine if homebound adults would use other alternative therapies if they were able to leave home.
REFERENCES
References


APPENDIX A

BARRETT FOLK/ALTERNATIVE HEALTH INFORMATION SURVEY
Please 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. County: _____________________________ 

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 

7. Average yearly income: Circle the category that is closest to your HOUSEHOLD income:

   A. Under 10,000  B. 10,000 – 20,000  C. 20,001 – 40,000  
   D. 40,000 & above 

8. Health insurance: Circle the correct response(s). 

   A. Not covered by insurance  
   B. Individual policy  
   C. Medicaid  
   D. Coverage through employer  
   E. Medicare  
   F. Other: ________________
9. For the next 5 sections, please circle those items you have used within the PAST 2 YEARS to treat an illness or maintain your health.

A. 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. Circle those HERBS you have used to treat an illness or used to maintain your health:

12) agrimony 23) balm 34) chamomiles 45) germander
13) aloe 24) black cohosh 35) comfrey 46) ginseng
14) angelica 25) milk thistle 36) dandelion 47) ginko biloba
15) anise 26) cayenne pepper 37) garlic clove 48) jimson weed
16) bayberry bark 27) catnip 38) ginger root 49) yellow root
17) goldenseal 28) red raspberry 39) oak leaves 50) horehound
18) saw palmetto 29) garden sage 40) mullein weed 51) witch hazel
19) fever few 30) red elm 41) red oak bark 52) fox glove
20) valerian 31) cranberry fruit 42) sassafras 53) echinacea
21) peppermint 32) hawthorn berries 43) St. John’s wort
22) pepper 33) cabbage leaves 44) wild cherry bark

Other(s):
C. Circle those items you have TAKEN BY MOUTH to treat an illness or to maintain your health:

54) black pepper  62) beef liver  70) rice  78) megavitamins
55) cinnamon      63) beets     71) red clay  79) tobacco
56) lemon juice   64) black molasses 72) flour  80) snuff
57) honey         65) blackberries 73) eggs  81) kerosene
58) sugar         66) brewer’s yeast 74) coca cola  82) cod liver oil
59) alfalfa       67) castor oil  75) turpentine  83) melatonin
60) baking soda   68) onions     76) potatoes  84) glucosamin
61) vinegar       69) salt       77) whiskey  85) chondrotin

Other(s):

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

86) ammonia      94) butter     102) magnets  110) tea bags
87) perfume      95) lard       103) turpentine  111) raw onion
88) shoe polish  96) milk       104) kerosene  112) potato
80) tobacco      97) saliva     105) coal oil  113) baking soda
90) Vaseline     98) tooth paste 106) DHEA      114) fatback
91) bleach       99) urine      107) WD 40     115) linseed oil
92) cobweb       100) aloe vera 108) DMSO     116) soot ashes
93) gasoline     101) ion water  109) cabbage leaf

Other(s):
E. Circle any of the following SPIRITUAL, CULTURAL, or RELIGIOUS practices you have used to treat an illness or to maintain your health:

117) prayer  
118) mediation  
119) Tai Chi  
120) amulets  
121) yoga  
122) wear a coin around your neck  
123) religious clothing  
124) bracelets of string  
125) copper bracelet  
126) wearing garlic  
127) tie a cloth around your neck or other body  
128) wearing asefetida  

Other(s):

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

very poor health   excellent health

1 2 3 4 5 6 7 8 10

11. Rate how you feel today on a scale from one to ten. CIRCLE ONE:

very poor   excellent

1 2 3 4 5 6 7 8 10

12. How frequently do you visit a Health Care Provider for care? CIRCLE ONE:

At least once a month   At least once a year
At least four times a year   Less than once a year
At least once every five years
14. Have you ever withheld information regarding the use of alternative therapies from your Health Care Provider for fear of not being accepted, understood or ridiculed? CIRCLE ONE:

YES

NO

15. If you answered "Yes" to question 14, what was the provider's response?
15. Please list any other information or alternative therapies that you use or have used in maintaining your health in the space below.


APPENDIX B

LETTER OF PERMISSION TO USE THE
BARRETT FOLK/ALTERNATIVE HEALTH INFORMATION SURVEY
September 25, 1997

Jenny Barnes
11715 Hwy 371 North
Marietta, MS 38856

Wesley Barrett
62382 Hwy 25 Sough
Amory, MS 38821-8660

Dear Mr. Barrett,

I am presently a graduate student at Mississippi University for Women School of Nursing. I plan to do my research on alternative healthcare. I am writing to ask your permission to use the Barrett Folk/Alternative Health Information Survey in my research.

Thank you for your consideration in this matter. If permission is granted, please sign in the space provided below.

Sincerely,

Jenny Barnes

Signature: Wesley Barrett, FNP
APPENDIX C

LETTER OF INSTITUTIONAL APPROVAL
April 8, 1998

Ms. Jenny Barnes  
c/o Graduate Program in Nursing  
Campus

Dear Ms. Barnes:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research as submitted. The Committee found your consent form to be exceptional and recommended that it be the standard used by the Division for future reference.

I wish you much success in your research.

Sincerely,

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

cc: Mr. Jim Davidson  
Dr. Mary Pat Curtis  
Ms. Lorraine Hamm
APPENDIX D

CONSENT TO PARTICIPATE IN THE STUDY
Dear Home Health Patient,

I am presently a graduate student at the Mississippi University for Women and am conducting a research project to fulfill the requirements for graduation. The study is to identify the alternative health practices of Home Health adults in Northeast Mississippi. This study will help primary care providers to better understand the alternative health practices utilized by Home Health patients. Alternative therapies are becoming very popular and widely used by consumers. I am very interested to know which, if any alternative therapies you might be using.

I would like your permission for your nurse to ask you some questions and complete a survey form pertaining to your use of alternative health practices. The information that you give will be held in the strictest of confidence and will be used only for the purposes of this study. The decision to participate or not to participate in the study will in no way impact the care you receive from this agency. Your name will not be used within the study. Your participation is strictly voluntary and you may withdraw at any time prior to your nurse leaving your home with the survey.

Please be honest in answering the questions and be assured that many, many people use alternative therapies. Your honest answers will hold a wealth of information for this study. Thank you very much for your consideration to participate in this study.

Sincerely,

Jenny Barnes, RN, BSN

I have read or been read the above information. I understand the meaning and the purposes of this study and understand that by my signature I agree to participate in the study.

Date ____________________  Signature ____________________