Use of Complementary and Alternative Health Practices of Persons Served by a Remote Area Medical Clinic

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Abstract:

Remote rural communities are often without adequate healthcare resources. To address the need in one area of Appalachia, an annual medical clinic is held to provide free healthcare services to residents of Appalachia. The Appalachian culture has a number of unique features that influence the healthcare practices of persons living in this region. Cultural values and beliefs about health and the use of complementary and alternative therapies among those attending the remote rural clinic are described, with faith healing, including prayer, and family-taught remedies being the most commonly used complementary and alternative medicine modalities.

Keywords: Appalachia | complementary and alternative medicine | folk medicine | rural healthcare

Article:

Appalachian culture and society have typically lagged behind the rest of the country, owing in part to the region's rugged terrain and geographic isolation.[1] The Appalachian people have been noted to display a mistrust of outsiders, which is thought to stem from the fact that many natural resources of the region have been exploited by non-Appalachians.[2] However, some characteristics associated with the people of the region have lessened as the geographic and social boundaries surrounding Appalachia erode as a result of the development of greater infrastructure and increased access to mainstream culture through the media of television and radio. Despite the influences from outside the region, many Appalachians continue to treasure their unique culture and seek to preserve traditional lifestyles and practices.[3,4]

In addition to isolation from the rest of the country, residents of rural Appalachia have often been stereotyped and marginalized, and until recent decades, there have been few efforts to understand fully the unique features of Appalachian culture. This can be seen in the area of healthcare beliefs and practices[2,5] that include traditional and family remedies collectively referred to as “folk medicine” by society at large as well as by members of the healthcare system. The term

"folk medicine" has a pejorative, patronizing connotation and fails to take into account the fact that many societies in the world, and a growing segment of society in the United States, use complementary and alternative medicine (CAM).[6,7] An understanding of and respect for the beliefs and values of the Appalachian culture is essential for the success of any healthcare practitioner who provides care to Appalachians.[2,8]

Limited access to resources may have led Appalachians to conclude that they have little personal power and few options available to them.[4] Consequently, this fatalism plays a key role in the healthcare beliefs of persons living in the region and has been shown to be a major barrier to cancer screening in Appalachia.[9] This fatalistic perspective influences the "here and now" orientation displayed by many Appalachian people, limiting their views about the future.[4] These perspectives are likely to influence the resistance to changing negative health behaviors, such as smoking or poor diet, given that the people of the region feel it is up to God to determine whether or not they become ill.[8,9] The Appalachian people may also be reluctant to listen to expert opinion or to comply with medical treatment because they believe their healing and wellness are maintained or revoked by God.[5,10,11]

Thus, outsiders visiting the Appalachian region readily observe that religion is central to the Appalachian culture,[11] with a heavy emphasis on Biblical teachings and individual salvation through Jesus Christ.[1] Some contemporary Appalachians attend churches[11] native to the region, such as the Pentecostal Church of God, founded in the late 1800s in rural Tennessee, which encourages a literal interpretation of the Bible and service through the church.[12] The church and its religious activities (e.g., prayer and church attendance) are seen as vital sources of healing.[6,11] This is particularly evident among older Appalachian residents, who desire to have a spiritual element in their healthcare and readily identify the many ways in which prayer and spirituality aid their physical health and their overall sense of well-being.[10]

Whereas the use of traditional family and community remedies is frequent among this population,[4,5,13] reported use is less than commonly thought,[2,8] which provides rationale to further examine this discrepancy and obtain data on the current health practices of the people of Appalachia attending the rural Remote Area Medical[14] (RAM) clinic.

In considering the many reasons for CAM use among Appalachian people, it is important to recognize that CAM use is a growing trend in America regardless of income, cultural background, or access to allopathic medicine.[6,15,16] As many as 44% of Americans use some form of CAM regularly,[16] and some view folk medicine as a basic and essential form of CAM.[7] Therefore, the use of family-taught Appalachian remedies such as herbal poultices, teas, honey, lemon, vinegar,[13,17] and moonshine whiskey[18] may be viewed simply as biologic CAM. Many of these remedies were passed on to the Appalachian settlers by the indigenous people of the area[13,17] and have been in use in Appalachia for centuries to treat infection, allergy, and respiratory ailments.

There are a number of practical reasons why Appalachians often turn to the use of family-taught remedies. Although there is greater access to healthcare in rural Appalachia today than in the past, barriers to conventional healthcare, such as lack of transportation and distance from healthcare providers, remain.[19,20] Even when transportation is not a problem, the time that

elapses from making an appointment to the date of the appointment is often a factor, as many rural Appalachians report that they must wait several months for a doctor's appointment and then often spend hours waiting to receive care.[19] Many rural Appalachians lack any form of health insurance, and those who have insurance may not be able to afford co-payments or prescriptions.[5,20] These factors contributed to the need for and subsequent development of the RAM clinic in remote southwestern Virginia[21] and the author's desire to learn more about the health practices of people who attend the clinic.

METHODS

A descriptive, mixed-methods, population-based study was conducted to identify the current health beliefs and practices and CAM use among persons seen at the RAM Clinic in rural southwestern Virginia. The study was approved by the University of Virginia Institutional Review Board for the Social and Behavioral Sciences.

Sample, setting, and procedure

A convenience sample of volunteer participants aged 18 years and older was recruited during a recent annual RAM clinic. The sample, although volunteers, was likely a representational cross section of adult residents of rural Appalachia seeking medical care at this clinic.[21]

A survey tool was used to collect demographic and study-related information from all participants, and confidential in-depth interviews were held with a subset of study participants. The 5 CAM modalities included on the survey instrument (chiropractic, herbal treatments, family- or community-taught remedies, massage, and prayer and faith healing) were selected based on 2 earlier studies[13,16] that identified these modalities to be more commonly used than others, particularly among residents of rural Appalachia.

Interviews were conducted in a private section of the medical clinic. The structured interview questions focused on health beliefs, access to healthcare, use of specific family- and community-taught remedies, and religious beliefs and their impact on the Appalachians' health practices. The interviews were transcribed and analyzed for themes. Volunteer participants who completed the survey tool were not compensated; however, those who participated in the structured interviews were given a $10 gift card as payment for their time.

RESULTS

A total of 133 volunteers completed the survey instrument that sought demographic data and information about the respondents' health problems and CAM use. Of 133 completed surveys, 125 were usable for data analysis. The survey data are summarized in Table 1.

Data from the 8 interview participants were transcribed and coded. Segments of feedback were collected, organized, and placed in categories, permitting description of commonalities. Themes generated from the data include (1) frustration with the lack of access to the current system of medical care; (2) preference to be treated by a medical doctor, that is, an MD, rather than an alternative healthcare provider; (3) perception of nonpersonalized care leading to dissatisfaction

with the current healthcare system; (4) willingness to try the familiar types of CAM practices; (5) use of family and community remedies; and (6) role of religious beliefs in healthcare practices.

Table 1. Characteristics of participants ($N = 125$)

Characteristics	Range	Mean
Age	19–77	44
Miles to healthcare provider	1–70	10
	n	**%**
Gender		
Male	38	30
Female	86	69
Not indicated	1	1
Residence		
Virginia	109	87
Wise county	41	33
Dickenson county	24	19
Russell county	11	9
Buchanan county	5	4
Lee county	10	8
Washington county	1	1
Scott county	6	5
County not indicated	11	9
Tennessee	3	2
Kentucky	3	2
South Carolina	3	2
North Carolina	3	2
Georgia	1	1
Residence not indicated	2	2
Number of people in home		
1	16	13
2	39	31
3	26	21
4	21	17
5	10	8
6	8	6
7	1	1
8	0	
9	3	2
Education		
Less than high school	15	12
Some high school	27	22
Finished high school/GEDs	55	44
Some college	17	14
Completed college	4	3
Postcollege, including master's	3	2
Employment status		
Employed	32	25
Unemployed	93	75
Insurance		

Uninsured	77	62
Insurance of any kind	48	38
Car ownership		
Yes	97	78
No	28	22
Chronic health problem*		
Yes	57	46
No	68	54
CAM usage		
Any form	99	79
Faith healing/prayer†	79	63
Family remedies‡	31	25
Herbs§	26	21
Chiropractic	24	19
Massage	23	18

∗Most commonly reported chronic health problems were back pain, arthritis, hypertension, and diabetes.
†Among respondents who used CAM, the most commonly used form was faith healing/prayer (63%), which was also used with greater frequency than other methods (35% reported everyday use; an additional 11% reported weekly use). Other methods of CAM were used once a month or less.
‡Of those who used family remedies, only 7% reported weekly or daily use, whereas 13% used a family remedy less than once a month. Remedies included were teas (n = 6), including catnip or blackberry teas, plasters or salves (n = 3), and hot/cold remedies (n = 3) such as hot baths or ice packs.
§Goldenseal (n = 4), ginseng (n = 3), echinacea (n = 3), green tea (n = 3), and black cohosh (n = 3). CAM indicates complementary and alternative medicine; GED, general educational development.

Frustration with the lack of access to healthcare

In most of the interviews, participants expressed frustration with their lack of ability to access healthcare. One participant stated, “I don't really have medical care; I just can't afford it,” and “I don't have access to testing … that I need because I have no insurance.” Another participant, who had lived outside Appalachia for many years before returning home to care for his aging parents, stated, “I have a Master's degree; I've traveled the world, and I can't afford healthcare now that I have returned to this region.” The responses of these individuals clearly reveal their frustration with access to care because of their limited financial resources and perhaps a sense that they have few options available to them.

Perception of nonpersonalized healthcare leading to dissatisfaction

Several respondents indicated that a lack of personal treatment and care had influenced their dissatisfaction with the current healthcare system available to them. One man stated, “Sometimes the doctors around this area seem to care more about talking to other doctors than they do about talking to you, and they seem like they don't really care….” A woman noting her dissatisfaction stated, “Doctors are always in a hurry, pushing you in and out.” Another female respondent indicated that the long wait for care was a source of major frustration and dissatisfaction with care in the region.

Preference to be treated by MD rather than alternative healthcare provider

Despite the frustrations and dissatisfaction with the healthcare system expressed by the respondents, most of them indicated that they would prefer to be treated by a medical doctor rather than an alternative healthcare provider because they believed that allopathic medicine is generally unsuccessful in treating or curing illnesses.

Only 1 participant reported that he had ever visited an alternative healthcare provider other than a chiropractor; the majority seemed uncertain about what type of care alternative healthcare providers might offer. One woman stated, “I went to a chiropractor, but I quit because … I couldn't afford it. The one [chiropractor] I went to seemed like he was good, but, I don't know. I'm sort of confused about it.” The remainder of the respondents interviewed reported that they had no confidence in the ability of alternative healthcare providers to treat and/or cure illnesses.

Willingness to try familiar CAM practices

Interview participants said that they were willing to try various methods of CAM, such as chiropractic and herbal therapies, although there was a general skepticism or lack of knowledge concerning methods of CAM that the respondents had not tried personally. Several respondents indicated that they had tried chiropractic treatments and had found the treatments to be helpful.

One man said, “I've been to a chiropractor once or twice and that seemed to have helped some.” Two other respondents noted, “I'll try anything once, and if it will help me, I'll try it again.” “I will try it [CAM] if I have to.”

Use of family- and community-taught remedies

The majority of those interviewed reported previous or current use of the family- and community-taught remedies. Use of these remedies is likely associated with the preference expressed for home treatment for minor ailments such as a sinus headache, poison ivy, colds, and constipation. One respondent stated, “I use *Vicks* salve on a fungus infection between the toes; drink lemon juice if I feel like my blood pressure is not right and I'm out of medicine.” Most of the participants interviewed indicated that they had found the following remedies helpful: “honey for sores and cuts,” “apple cider vinegar for sunburn,” “moonshine whiskey and horehound candy with sugar as a cough syrup,” and “turpentine for any cut or for a stomachache with a little bit of sugar added.” Respondents did not view any family-taught remedies as a form of CAM.

Role of religious beliefs in healthcare practices

The majority of the respondents expressed the importance that their religious beliefs have in healthcare practices. One woman indicated that prayer guides her decisions regarding medical care. She stated, “I pray, first of all, about everything, and I try to decide where I should go, and then seek medical attention.” Other comments on the role of faith and prayer in healthcare included, “I know the Lord can heal, but he gives the knowledge to the doctors, that they can heal through him.” “I believe in prayer, and I trust God. So many times, I'm hurting, and I trust God will heal me.”

DISCUSSION

Despite a common perception that Appalachians live with large, extended families, most respondents surveyed at the remote healthcare clinic live in households with 3 or fewer family members, a finding consistent with the research of Huttlinger and colleagues,[21] who also found smaller household sizes among patients seen at rural healthcare clinics in Virginia and Tennessee. More than half (63%) of the 125 clinic attendees surveyed have a high school education or a general equivalency diploma, a finding contrary to the belief of many outside the region that Appalachians are uneducated.

The 125 survey respondents reported that they live, on average, 10 miles from a source of healthcare, although those who attend the annual RAM clinic must drive many miles farther to receive care at the clinic, suggesting that barriers to accessing healthcare are more likely related to financial issues or affordability of care rather than geographic distance to and from a source of healthcare. However, for nearly one third of the Appalachians who attend the annual RAM clinic yet reported they do not own a car or truck, access to transportation may be a major barrier to healthcare.[20]

The study findings are consistent with prior research by Huttlinger et al,[21] who found that rural Appalachians living in southwestern Virginia expressed a desire for allopathic healthcare but are unable to afford or access adequate care. Statements from participants interviewed substantiate previous research[5,8,22] that Appalachians value personalized care within the conventional healthcare system. Use of chiropractic, the one CAM therapy that several participants reported using, has been theorized to be related to a preference for personal contact and therapeutic touch among this population.[5] Prior studies have reported higher use of chiropractic in medically underserved rural areas[23] than was found in this study.

Participants expressed a sentiment that healing was guided by God, which is also consistent with the findings of prior studies.[10,11] A national study on the use of prayer for health concerns found that 35% of respondents use prayer.[24] The fact that the use of prayer was significantly higher among this study population underscores the deep religiosity of many Appalachians.[10,11] These findings suggest that prayer and faith healing may be used for health maintenance on a continual basis, whereas other methods are used only when the person feels ill or in need of additional treatment. Although many of the respondents indicated that faith plays a key role in any medical decisions, there was no indication that they rely exclusively on faith healing or prayer as a treatment method.

The findings were consistent with those of Arcury and colleagues,[13] who have reported a higher prevalence of CAM usage among residents of rural Appalachia than the general population of the United States. Also, as in Arcury's research, many reported that family remedies included some combination of honey, vinegar, lemon juice, teas, and moonshine whiskey.

The findings of this study support the commonly held belief that Appalachians, like the general population, use selected forms of CAM. The rate of CAM use is significantly higher than the national average of 44%.[16] Faith healing, including prayer, was the most commonly used CAM modality, followed by the family- or community-taught remedies. Although there are no major

contributing factors to CAM usage among the Appalachian population, the study data indicate that dissatisfaction with the healthcare system, perceived benefits of family-taught remedies, and religious beliefs and values all play a part. The therapeutic value of participation in spiritual-related activities and the use of prayer for mental and physical health are well documented elsewhere.[25,26]

CONCLUSION AND IMPLICATIONS

Remote healthcare clinics are unique settings in which to explore the use of CAM among those seeking healthcare. This study found a high rate of CAM use among rural Appalachians. Faith healing and prayer were the most common form of CAM used, followed by family- and community-taught remedies. These findings substantiate much of the existing body of research on the use of alternative healthcare practices among the Appalachian population[2,10,13] and support the notion that Appalachian culture has a number of unique features that influence the healthcare practices in the region. Healthcare providers working with Appalachians should ask about CAM usage and assess its impact on patients' overall health and receptivity to allopathic treatment methods. The findings of this study contribute to the existing body of research on CAM use among the Appalachian population and may prove useful in guiding the development of future remote rural events and encourage open discussion of CAM use with patients seen at these temporary clinics.

Future research is needed to elaborate on these findings, with a specific focus on further assessing the contributing factors behind CAM usage in the current population of rural Appalachia. Although there has been recent research on Appalachians' healthcare access, there is a dearth of information indicating whether or not this lack of access and affordability of healthcare drives the continued use of “folk remedies” among this population. Future research in this area could also focus on the persistent use of specific remedies to determine whether or not these possess the curative effects that many Appalachians have experienced.

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