Home Remedy Use Among African American and White Older Adults

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Abstract: Home remedy use is an often overlooked component of health self-management, with a rich tradition, particularly among African Americans and others who have experienced limited access to medical care or discrimination by the health care system. Home remedies can potentially interfere with biomedical treatments. This study documented the use of home remedies among older rural adults, and compared use by ethnicity (African American and white) and gender. A purposeful sample of 62 community-dwelling adults ages 65+ from rural North Carolina was selected. Each completed an in-depth interview, which probed current use of home remedies, including food and non-food remedies, and the symptoms or conditions for use. Systematic, computer-assisted analysis was used to identify usage patterns. Five food and five non-food remedies were used by a large proportion of older adults. African American elders reported greater use than white elders; women reported more use for a greater number of symptoms than men. Non-food remedies included long-available, over-the-counter remedies (e.g., Epsom salts) for which "off-label" uses were reported. Use focused on alleviating common digestive, respiratory, skin, and musculoskeletal symptoms. Some were used for chronic conditions in lieu of prescription medications. Home remedy use continues to be a common feature of the health self-management of older adults, particularly among African Americans, though at lower levels than previously reported. While some use is likely helpful or benign, other use has the potential to interfere with medical management of disease. Health care providers should be aware of the use of remedies by their patients.

Keywords: complementary medicine ■ qualitative research ■ rural

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INTRODUCTION

Older adults draw on a variety of regimens to address common health complaints. While professional medical care is the most visible source of health care, it is rarely accessed first. Instead, older adults take other steps to relieve symptoms before calling upon professional medical care. They may engage in self-care behavior such as resting, providing self-treatment—including home remedies, using non-prescribed medications, or some combination.[1] Existing theory, including Haug's model of self care[2] and Leventhal's common-sense model of self-regulation (CSM), predicts that older adults will use a variety of forms of self-care to alleviate commonly experienced symptoms.[3,4] An often overlooked form of self-care is the use of home remedies.

Home remedies are substances used to treat common symptoms and ailments. They can be divided into food products and readily available non-food household products.[5] When employed as home remedies, many of these food and non-food products are typically used for purposes other than that for which they are sold. Non-food home remedies are products and agents used for health that have been available to consumers for decades. Some were originally marketed for health purposes, but their uses have been extended by consumers beyond their labeled use. Others were never intended for health purposes, but are used for health purposes now. Sources of knowledge for the use of home remedies can be traditional (learned about as children and young adults from parents and grandparents) or contemporary (learned about from books, periodicals, television or the internet).

Regional studies of rural older adults indicate that over half use some type of home remedy.[5,6] Some of the health care literature has captured aspects of home remedy use;[1,2,7–12] however, the literature is quite sparse. Research on the use of folk remedies among white Appalachian elders and rootwork among African American elders, although scant, has encompassed home remedies.[13–16] Earlier studies, such as Loudell Snow's ethnography of African American folk medical systems, found extensive use of remedies by African Americans.[17]

Home remedies are rarely included in contemporary surveys of complementary and alternative medicine (CAM).[18,19] Even when included, analyses often fail to report on the use of home remedies as a separate category.[20,21] Those studies that do report on home remedy use do not distinguish among the specific home remedies used, obscuring the range of symptoms that individuals treat with particular remedies. Multiple studies have simply asked participants whether they have used home remedies without significant prompts.[21–23] Such an approach is likely to miss much of home remedy use.[24] Additionally, studies that recruit from limited types of sites[22] or that exclude individuals who do not report home remedy use while growing up[25] provide biased results. These study limitations hamper gaining a comprehensive understanding of the range of home remedies that people use to treat their health

problems and symptoms and, in particular, the distribution of use by such characteristics as ethnicity and gender.

Leventhal and Haug emphasize the effect of the socio-cultural context on individuals' interpretation of specific bodily conditions or symptoms. Their particular social context may affect their interpretation of the severity or significance of a symptom; previous experiences shape their exposure to and assessment of various forms of treatment.[2,3] Limited access to allopathic medical care during periods of one's life span, experiences of discrimination and knowledge of racist treatment by the health care system, and cultural knowledge about specific home remedies are affected by one's ethnic background.[13,15] Several studies have found African Americans,[6,23] Native Americans,[6] and Hispanics[20] are more likely to report home remedies than whites. Gendered norms regarding caregiving responsibilities,[26] particularly the provision of care to family members who are ill, may affect the transmission of knowledge regarding home remedies within families. Specific use of home remedies may be affected by gendered norms as well.

Research on variation of home remedy use by gender is mixed. Analysis of data from the National Study of African Americans (NSBA) indicated that women were more likely than men to report having used home remedies;[25] Brown and Segal, however, found that after controlling for socioeconomic variables, gender did not significantly affect home remedy use.[23]

This paper expands our knowledge of practices of self-management in several ways. It explores an aspect of self-care, use of specific home remedies, that has largely been overlooked by previous research, and examines the range of symptoms that elders address by a particular food or non-food home remedy. By including both men and women of different ethnic groups from the same geographic region, we are able to analyze how both ethnicity and gender may affect home remedy use, expanding the complexity of our understanding of the effects that ethnicity and gender may simultaneously exert on choices regarding self care.

The goal of this paper is to extend the study of health self-management to include home remedies. Using data from a qualitative study of health self-management in a bi-ethnic sample of older rural adults, we will (1) document the level of use of home remedies among older rural adults, (2) document the purposes for which home remedies are used, and (3) compare this use by gender and ethnicity.

METHODS

Sample

Participants were recruited from three rural south-central North Carolina counties where the lead investigators have conducted research on health disparities since 1996. The sample was designed to recruit 60 participants with equal numbers of African American and white women and men (15 in each cell). A purposive sample design was used to recruit representative participants who reflect the range of knowledge, beliefs and practices in that community.[27] In addition to recruiting participants from numerous sites in the counties and ensuring an approximately equal distribution by sex and ethnic group, attention was paid to the educational attainment and migration history in recruitment to maximize variation in sampling. A site-based procedure was used to implement the sample design.[28] Sites are places, organizations, or services used by members of the population of interest. We recruited participants from 26 sites across the study counties that served the different ethnic groups and social groups, ending recruitment once saturation was reached.

Data Collection

Data were collected from February through October, 2007, by five interviewers. Interviewers met participants at a location of the participants' choice, usually the participants' homes, and obtained signed informed consent as approved by the Wake Forest University Health Sciences Institutional Review Board. Participants received a small incentive ($10) at the end of interview. In-depth audio recorded interviews ranged from one to three hours. An interview guide, grounded in Leventhal's Self-Regulatory Model[3,4] and Kleinman's Explanatory Models of Illness[29] was developed and pilot-tested. The guide focused on knowledge and use of complementary therapies, including history and purposes for use, beliefs regarding effectiveness, and relationship to utilization of conventional medical care. The interview guide took both an illness- and symptom-centered approach, asking participants how they typically managed common illnesses and symptoms, and a treatment-centered approach, in which participants were asked what they knew about common treatments. This latter section included a variety of food and non-food home remedies. Informants were asked to distinguish historical use from current use.

The lists of home remedies queried were derived from over a decade of fieldwork by the authors and others in the rural South.[1,14,24] The lists were restricted to items frequently mentioned in prior data collection, commonly available in the population, and that had significant time depth. The food home remedy list included honey, lemon, vinegar, baking soda, and salt. The non-food over-the-counter list included alcohol, Epsom salts, oils, Vaseline, and Vicks VapoRub.

Data Analysis

Data analysis used a systematic, computer-assisted approach. Interviews were transcribed verbatim and edited for accuracy.