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Use of unconventional therapies by primary care patients — Religious resources vs. complementary or alternative medicine services

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Summary
Objectives: The study examines the difference in characteristics between primary care patients who turn to ''religious resources for medical purposes'' (RRMP) and those who turn to ''complementary or alternative medicine'' (CAM) services to cope with a physical or mental health problem.
Design and setting: Data were collected from eight primary care clinics in Israel and included 905 Jewish patients aged 25—75.
Main outcome measure: A self-report questionnaire with a battery of validated mental health assessment instruments and two questionnaires regarding use of unconventional therapies (RRMP and CAM services) were administered to the participants. The association of various variables with type of 'service use' was examined through logistic regression analysis.
Results: Primary care patients suffering from emotional problems have a propensity to utilize unconventional therapies in addition to conventional medical treatment. However, differences exist between patients who turn to RRMP and to CAM. The risk factors for turning to RRMP are North African, Middle Eastern or Israeli origin, low SES, religious observance, and high use of primary care clinics. For using CAM services the risk factor is high SES.
Conclusions: In the present study, a quarter of primary care patients also use additional resources for their medical problems. While all segments of the population use unconventional resources, our study reveals that two types of unconventional therapies — RRMP and CAM — tend to be used by two different population sectors. It is noteworthy that those suffering from mental health problems are more likely to utilize unconventional resources.

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It is well established that users of primary care services also turn to other resources for health care. For example, in 2001 a national survey in the United States[1] revealed that, among those who used conventional medical treatment, 23% also used complementary or alternative medicine (CAM) services. Our definition of CAM follows that of the National Center of Complementary and Alternative Medicine: ''a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period''.[2] Following the growing use of CAM, some studies have been published regarding the characteristics of the patients who use CAM services for medical or mental health problems.[3–8] There are also many studies which indicate the importance of religiosity and spirituality in coping with mental and somatic health problems,[9–12] and some physicians even claimed that ''the medicine of the future is going to be prayer and Prozac''.[13] However, relatively little research has been performed on primary care patients who turn to religious resources for medical purposes (RRMP), like consulting a religious authority or pilgrimages to tombs of Jewish saints. To the best of our knowledge, there is no study on the difference in characteristics between primary care patients who turn to religious resources and those who use CAM services to cope with medical problems. The present study was conducted on Jewish primary care patients in Israel. Jewish religious observance is an integral part of the Jewish national identity, even among those who define themselves as secular.[14] A significant segment of the Jewish population consults a rabbi for a variety of personal issues including medical problems (13%) and even a greater proportion of them see benefit in visiting the tombs of Jewish saints (24%).[15] This phenomenon is similar to pilgrimages to shrines and graves found in Christianity[16] and Islam.[17] In the current study, turning to RRMP as well as CAM were considered as 'unconventional therapies'. In the present study we described and compared the characteristics of primary care patients who turn to RRMP and of those who turn to CAM services, while also examining the impact of mental health problems on the type of unconventional services used.

Methods

Sample

The study population consisted of primary care patients who, at the time of the study (2002–2003), were between ages 25 and 75 and visited one of eight selected clinics in Israel's largest HMO[1] during the year prior to the interview. In the present study, which is part of a larger study on rates of utilization of the primary clinics,[18] younger adults (<25) were excluded because they usually utilize army medical services and older adults (>75) because they generally have higher utilization rates due to increased somatic problems. The clinics were selected to represent a cross-section of the Israeli population on the basis of geographic, socioeconomic and ethnic diversity. Although the sample included Israeli Arabs (7% of the sample), the present analysis focuses only on Jewish patients ($N = 905$) since a main variable is religious behavior, which differs in the two population groups. The sample was constructed by interviewing consecutive patients who were screened by a short questionnaire in order to select those who met the study criteria (age 25–75 and at least one visit during the year prior to the interview). Respondents were recruited by specially trained interviewers. The nature of the study (research about use of primary clinics by patients) was explained and only those who signed informed consent forms (77% of those eligible) were included. Patients were fully interviewed at home in Hebrew or Russian, according to respondents' request. The study protocol and instruments were reviewed and approved by the medical director of the HMO as well as the medical directors of the eight selected clinics.

Measures

Three self-rating mental health assessment instruments, with previously established reliability and validity, were administered:

1. The Brief Symptom Inventory – 18 (BSI-18) a shortened version of the BSI, a self-report scale for identifying psychological distress, which includes subscales for somatization, depression, and anxiety, as well as an overall index, the Global Severity Index (GSI). The BSI-18 internal consistency estimates are quite satisfactory.[19] Cronbach's alpha in our study was .88. The instrument is scored by converting total scores on each of the scales into *T* scores based on Israeli normative data from the community.[20] A score of 63 or higher on the GSI or at least on two of the three subscales indicates clinical ''caseness''.
2. The Composite International Diagnostic Interview – Short Form (CIDI-SF), a diagnostic instrument developed by the WHO specifically for diagnosing mental health problems in epidemiological studies.[21] This instrument diagnosed patients with depression or with anxiety (general anxiety, panic disorder or obsessive compulsive disorder – OCD). For depression, panic disorder and OCD, the CIDI-SF algorithm does not give a precise cut-off point for diagnosis, but provides the probability of a diagnosis for different scores. In our study, a score of 4–7 defines a diagnosis of depression (probability of 81–91%); for panic disorder, a score of 3–6 is required (probability of 87–100%) and for OCD, a score of 3 (probability of 84%).
3. The somatization subscale of the Symptom Checklist-90 (SCL-90) questionnaire: 12 questions on symptoms of somatization, each one with a five-category response: not at all (0), a little bit (1), moderately (2), quite a lot (3) and extremely (4).[22] A score of 3 or higher on at least six of the twelve symptoms was considered as indicating possible somatization. The somatization questionnaire was found to be highly reliable (Cronbach's alpha = 84).

Two self-report questionnaires concerned the use of unconventional therapies in addition to primary care services:

[1] Clalit Health Services HMO, which insures 60% of the Israelis.