Complementary and Alternative Therapies for Urinary Symptoms: Use in a Diverse Population Sample Qualitative Study

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Approximately 30% of men diagnosed with prostate disease take supplements, and doctors in Europe typically use remedies that include first-line treatment for urologic conditions (Chan et al., 2005; Lee, Chang, Jacobs, & Wrensch, 2002; Nickel, Shoskes, Roehrborn, & Moyad, 2008). Such use illustrates the growing popularity of complementary and alternative therapies (CAM) to treat illness and promote wellbeing. It is important for health care professionals to understand how patients use CAM in addition to and/or as a substitute for allopathic care.

CAM includes a set of diverse medical and health care systems, practices, and products that are not presently considered to be part of mainstream medicine (National Center for Complementary and Alternative Medicine [NCCAM], 2011). CAM practices can be classified into three main categories: a) natural products, including dietary supplements, herbs, vitamins, minerals, and probiotics; b) mind-body medicine, including meditation, yoga, hypnotherapy, deep-breathing relaxation exercises, and acupuncture; and c) manipulative and body-based practices, such as massage and spinal manipulation (NCCAM, 2011).

Study participants reported a range of remedies used to treat urinary symptoms, from popular products, such as saw palmetto, to less commonly known remedies, such as moabi. Participants learned about remedies through social networks rather than from their primary care provider.

Key Words: Complementary and alternative therapies, urinary symptoms, social relationships and health, Boston Area Community Health (BACH) survey.

The first representative U.S. survey of CAM use in 1990 estimated that 34% of U.S. adults had used at least one complementary therapy in the prior year (Eisenberg et al., 1993). Follow-up surveys document an increase in the use of CAM, up to 38% in 2007 (Barnes, Bloom, & Nahin, 2008; Tindle, Davis, Phillips, & Eisenberg, 2005). These and other surveys established an association between CAM use and being Caucasian or Native American (Bair et al., 2002; Egede, Ye, Zheng, & Silverstein, 2002; Fennell, 2004), female, younger than 65 years of age, having a
Research Summary

Purpose
The use of commonly known and studied treatments for urologic symptoms and conditions does not capture the full breadth of utilization, their use for other urologic symptoms, nor reasons for use. This qualitative study aimed to capture a fuller range of remedies used to relieve urologic symptoms.

Methods
Data come from a qualitative study conducted with a subsample of participants in the Boston Area Community Health (BACH) Survey. The study consisted of 151 respondents selected by stratified random sampling who reported one or more urologic symptoms. They were interviewed using open-ended questions that were recorded and transcribed verbatim.

Data Analysis
The “open coding” process accompanied general descriptive statistics, and transcripts were examined for thematic relationships across ethnic and gender groups.

Findings
Most complementary and alternative medicine (CAM) users did not expect their allopathic providers to have much knowledge regarding CAM, and they had also sought care from these providers. African-American men were the highest users of CAM in this study (44%), and use was more frequent for all users of higher socioeconomic status. Participants reported a wide range of potential remedies, some of which were provided by family in other countries.

Level of Evidence – VI (Melnyk & Fineout-Overholt, 2011)

High school education or greater, residing in the Western U.S., and earning higher incomes (Barnes et al., 2008; Eisenberg et al., 1993, 1998; Tindle et al., 2005). While these quantitative studies provide a snapshot of typical CAM users, other studies complicate the notion that CAM users fit a specific profile. Some studies challenge the finding that African-American individuals and those of Hispanic origin are less likely than Caucasian individuals to use CAM, suggesting different patterns of use, with non-Caucasian populations being as likely (Astin, 1998; Mackenzie, Taylor, Bloom, Hufford, & Johnson, 2003; Sturm, 2000) or more likely as Caucasians to use CAM (Bell et al., 2006; Bishop & Lewith, 2010). In a comprehensive review, Bishop and Lewith (2010) found 38 studies in which Caucasians were more likely to use CAM, while in 15 other studies, non-Caucasians were more likely to use CAM.

It is also important to understand what specific treatments are used and how the use of specific modality varies by sub-population. Barnes and colleagues (2008) stated that in a national survey, the most popular forms of CAM therapies include non-vitamin, non-mineral natural products (17.7%); deep breathing exercises (12.7%); meditation (9.4%); chiropractic or osteopathic manipulation (8.3%); and yoga (6.1%). Another recent national survey indicates that individuals use CAM to treat specific problems, and in this case, to treat various musculoskeletal problems, including back pain, neck pain, joint pain, and arthritis (Barnes et al., 2008). However, how specific types of CAM are used by different sub-populations is not as well understood.

Despite its growing popularity, research indicates that patients often do not discuss the use of CAM with their primary health care provider, with only about one-third of CAM users reporting they discussed their use of complementary therapies with their clinicians (Adler & Fosket, 1999; Herman, Allen, Hunt, Prasad, & Brady, 2004; Kennedy, Wang, & Wu, 2008; Sleath, Rubin, Campbell, Gwytter, & Clark, 2001). Disclosure rates were significantly lower for males, younger adults, racial and ethnic minorities, and less intensive users of medical care (Kennedy et al., 2008). Non-disclosure of CAM use to clinicians may contribute to missing the identification of potential herb-drug interactions. While it is clear that individuals do not discuss CAM use with their primary and specialty health care providers, how individuals use CAM in relation to the other health care they receive is not well understood.

The current study focuses on modalities used to address a specific set of symptoms – urinary symptoms – providing a unique opportunity to study the use of CAM for a more narrow set of problems. By focusing on urinary symptoms, we can better explore how CAM use for similar symptoms differs by social group. Using CAM for prevention purposes or to promote general well-being is very different from using CAM to treat a health problem once it has developed. It is therefore important to contextualize CAM use within a health condition. Researchers of prior studies have found that individuals with urinary symptoms often do not seek help for these conditions (Nicolson, Kopp, Chapple, & Kelleher, 2008; Sexton et al., 2009) and also lack knowledge of available medical treatments for urinary symptoms (Diokno, Sand, Macdiarmid, Shah, & Armstrong, 2006; Horrocks, Somerset, Stoddart, & Peters, 2004). Given the potential barriers to seeking help from allopathic health care providers, it is important to understand how individuals with urinary symptoms use CAM to relieve their symptoms.

According to the most recent national survey conducted in 2007, individuals use CAM to treat various musculoskeletal problems, including back, neck, and joint pain, and arthritis (Barnes et al., 2008). While urologic symptoms are not the most common conditions for which respondents in the most recent
A great deal of work has been done to assess the use of certain herbal therapies to manage urologic symptoms (such as saw palmetto), particularly among patients with prostate cancer. Herbal therapies (such as cranberry supplements) are also used as treatments for or prophylaxis against urinary tract infections (Allen, 2007; Dreikorn, 2005; Lowe & Patel, 2008). While a great deal is known about the use of certain popular remedies, the use of these more commonly known and studied treatments for urologic symptoms and conditions does not capture the full breadth of substances utilized, their use for other types of urologic symptoms, or purported reasons for their use. By probing CAM use in the context of a qualitative study, the current study is better able than quantitative surveys to capture a fuller range of remedies used to relieve a broader range of urologic symptoms.

This study addresses important questions about the use of CAM among a diverse sample of individuals who report urologic symptoms related to frequency, urgency, or leakage. Three main research questions were answered: a) who used CAM to relieve urinary symptoms; b) what specific CAM modalities were used; and c) how was CAM used in relation to the care received from mainstream health care providers?

Methods

Subjects

Data were obtained from a qualitative study conducted with a subsample of participants who reported a range of urologic symptoms in the Boston Area Community Health (BACH) Survey. BACH is a population-based, random-sample, epidemiologic survey of 5503 subjects. For this parent study, multi-stage, stratified cluster sampling was used to recruit 3202 women and 2301 men, 1767 African-Americans, 1877 Hispanics, and 1859 Caucasians. The sampling design and study methods (McKinlay & Link, 2007) for this larger epidemiological study (Fitzgerald, Link, Litman, Travison, & McKinlay, 2007; Tennstedt, Link, Steers, & McKinlay, 2008) have been previously reported.

Individuals were identified as having urinary symptoms if they reported “fairly often,” “usually,” or “almost always” for at least one of a range of questions about frequency (urinate again less than 2 hours, and frequent urination during the day), urgency (difficulty postponing urination, strong urge or pressure), and leakage (leakage of “even a small amount of urine”) (Fitzgerald et al., 2007; Tennstedt, Link, Steers, & McKinlay, 2008). Table 1 includes a summary of symptoms for the full sample and for those who used CAM (the subsample included in this analysis).

The sample for this qualitative study consisted of 151 respondents who reported one or more urologic symptoms on the BACH survey. Stratified random sampling was used to select these respondents from each of the six groups of the BACH sample. For the current analysis, the sample included 25 African-American women, 25 African-American men, 25 Hispanic women, 25 Hispanic men, 25 Caucasian women, and 25 Caucasian men. The respondents experienced a range of urinary symptoms, reporting urinary frequency, nocturia, urgency, and incontinence. One-quarter of respondents,
mostly Caucasian men and women, reported a history of urinary tract infections.

Data Collection Methods

The interview schedule included open-ended questions addressing the following content areas: description and characterization of symptoms; impact on daily life; feelings associated with and understanding of symptoms; norms; coping and management; and help-seeking from both family/friends and health care providers. For this analysis, researchers were particularly interested in responses to the following questions, in addition to any other mentions of self-care practices:

- People might do many different things for their health problems or symptoms besides going to the doctor. Other than going to the doctor, what kinds of things have you tried to make your urinary, bladder, or pelvic problems better?
- Have you tried changing your diet?
- Have you tried taking special herbs?
- Have you tried buying medicine without a prescription?
- Have you tried acupuncture, prayer, or other kinds of self-care?

Additionally, study participants were asked, “Have you ever talked with a doctor, nurse, or some other kind of health care professional about your bladder, pelvic, or urinary symptoms?”

The Institutional Review Board of the New England Research Institute approved this study. Trained interviewers conducted in-person interviews in respondents’ homes, and the interviews lasted about one hour. All interviews were digitally audio-recorded and transcribed verbatim. Spanish interviews were transcribed and translated into English. Transcripts were imported into Atlas.ti 5.2 qualitative analysis software for coding (Muhr, 2004).

Analyses began by generating a “start” or exploratory list of codes, a process referred to as “open coding” (Strauss & Corbin, 1998). Employing the “constant comparative” approach, the investigators met to compare and discuss their lists of themes and corresponding text identified for the codes (Glaser & Strauss, 1967). Inter-coder agreement was assessed until coders achieved 90% inter-coder agreement. Ongoing checks of coding consistency were conducted until coding was complete. Finally, patterns across transcripts and relationships among themes were examined and compared across gender and ethnic/racial groups.

Results

Results are organized around three main questions:

- Who used CAM?
- What specific remedies did study participants use to relieve urinary symptoms?
- How did study participants use CAM in relation to allopathic care?

The analysis of the qualitative data illustrates how the use of a wide range of remedies varied by race/ethnicity.

Who Uses Complementary And Alternative Therapies?

Alternative therapies were used for urinary symptom relief by 39 (26%) respondents. Table 2 includes a summary of CAM use across the entire sample, reported by race/ethnicity and gender. Use of therapies varied by race/ethnicity. Black or African-American men (44%) and women (40%) reported CAM use most frequently. The next highest rate of use was by Hispanic women (28%) and Caucasian men (23%). Caucasian women and Hispanic men reported the least use of CAM, with only 8% of Caucasian women and 12% of Hispanic men reporting use. CAM use was more frequent among participants of higher socio-economic status (SES) level and similar in relation to...
considering it to be an indicator of culture.

What Did Study Participants Use to Remedy Urinary Symptoms?

Study participants reported using a wide variety of substances, including an assortment of herbs and herbal teas, juices and other fluids, vitamins and minerals, other supplements, and over-the-counter (OTC) medications. Table 3 includes a comprehensive list of all substances reported by participants as treatment for urinary symptoms, ordered by overall frequency of report and by type of substance reported by race/ethnicity and gender. Cranberry juice, green tea, flaxseed, and vitamins were among the most commonly reported remedies mentioned. In addition to these better-known treatments, study participants mentioned at least 25 other less well-known remedies, reflecting a diverse set of therapies used to relieve urinary symptoms.

Results reveal a wide range of potential remedies for urinary symptoms, with some treatments clustering within some groups more often than other remedies.

Table 3.
Remedies Used by Race/Ethnicity and Gender

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<td>Moabi (colubrine elliptica)</td>
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<td>Other herbal tea</td>
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African-American men, the group with the most CAM use, mentioned a variety of therapies. Some took vitamins, saw palmetto, cinnamon, ginseng, moabi, aloe, yarrow, other herbs, and other herbal teas in addition to the more frequently reported cranberry juice and green tea. One male participant explained how moabi is used:

It’s like a plant that you boil and you add sugar to it. It’s called moabi... It comes from the back of a tree. I’ll show it to you... Like I said, they sell it over here in the tropical market. You go around the corner here. There’s one up there. That’s the only place I know they sell it... I like it because it’s got a nice taste. You’ve got to put a lot of sugar in it, though, because the moabi can be very bitter... is very bitter. I’ve got some on there right now. I boil it... I started using it more within the last year-and-a-half or so... It’s supposed to clean your blood... It’s just like Coca-Cola™. You drink Coca-Cola. You don’t know if it [has] any affects on you... but it’s just like when I was little my grandparents gave it to me. (African-American male, age 62, born in Trinidad)

Another African-American man, also born in Trinidad, described using moabi to “cool” his system:

Coolin’ to cool down the bladder... You know like we’ll get some different types of bush and boil it up... and the wife strains that, and I just drink that water to cool down the bladder and so on.

Study participants “cooled” the system with therapies other than moabi. This same man described using aloe to cool his system to relieve bothersome urinary symptoms:

Aloe plant. Just all these things. You know? And it cools the system. Sometimes that’s what your body needs. You know? And it keeps the system good. Yes. So we do all that.

Another African-American man described how green tea is used to “clear” an infection:

The green tea, you know, with the ECG or whatever they’ve got in it now, I’m hoping that brings up my antioxidant, which brings up my immune system and helps me fight off... I mean, if my bladder has an infection, this stuff is supposed to kind of help it and clear it out. (African-American man, age 42, born in the U.S.)

Black women reported using the commonly referenced cranberry juice and green tea, but they also mentioned using other liquids, such as fruit juices and tea.

Well, gee. I haven’t had that much of a problem, but I do try to, I don’t try. I eat healthy. I drink... blueberry juice and other fruit juices I think [are] fine. Pomegranate and that sort of thing. I eat a lot of fruits and vegetables. Other than that I don’t know. I drink tea. Green tea... (African-American female, age 81, born in the U.S.)

Black female respondents also mentioned using vitamins, ginseng, and spices (such as cinnamon and tumeric), and consuming fish oil. One African-American female also reported seeking acupuncture to address her urinary symptoms.

The only remedy reported by Caucasian women (n = 2) was cranberry juice, both mentioning its relief of urinary symptoms, but one reporting less relief than the other. Caucasian men used some of the more commonly used remedies, including cranberry juice, green tea, flaxseed, vitamins, and saw palmetto, for prostate health.

How Did Study Participants Use CAM in Relation to Allopathic Care?

Study participants were asked if they had sought care
from a physician, nurse, or other health care provider. Most (85%) of the 39 complementary and alternative therapy users had also sought care for their symptoms from a physician, nurse, or other health care provider. The thematic analysis of CAM use in relation to allopathic care revealed multiple strategies undertaken by respondents to reconcile different remedies. First, some individuals used CAM instead of more mainstream forms of health care. Reasons varied among those using CAM instead of allopathic care. Some study participants simply preferred CAM. One Caucasian woman (age 54) described her evaluation of herbal medicine compared to other prescription medications:

*I have a friend who practices herbal medicine, and I've learned over the years that she's probably right. And I would tend to do that before some sort of man-made combination of chemicals, even though those have been proven in the laboratory to be absolutely safe. I just – I don't know, I think I'd rather eat something that grows nearby.*

Other participants explained their preference for CAM because of their belief that certain medications for urinary symptoms were contraindicated because of medications taken for another condition.

For some, physicians did not provide a specific treatment. For example, study participants reported symptoms for which they sought relief, but their test results (such as PSA) were considered within normal range, and no medication or treatment was prescribed by their physician. It is not clear if these participants discussed their attempt to substitute CAM remedies and if/how these remedies were contraindicated with other medications.

A second strategy revealed in the thematic analysis of CAM's use in relation to allopathic care suggests that CAM was used as a first strategy before seeking allopathic care. In these cases, individuals used CAM as a form of self-treatment to see if it worked before seeking allopathic care. For example, some study participants reported self-treating urinary tract infections, usually at the emergence of symptoms. For example, this African-American woman (age 66, born in the U.S.) described how she used multiple types of juice and water before seeking care from her doctor:

*I try drinking cranberry juice. And I've tried apple juice and drinking lots of water. And it got a little better, but it still didn't go away, so I still eventually ended up at the doctor.*

The final strategy was using CAM as a secondary or backup strategy when allopathic remedies did not relieve symptoms. In such cases, study participants' symptoms continued after treatment (for example, after continence surgery that decreased but did not eliminate symptoms). For these individuals, CAM use represents an attempt to relieve symptoms that were not completely addressed through allopathic care.

It is not clear from study data if respondents learned about any of these complementary and alternative treatments from their allopathic health care providers. A few explicitly mentioned their doctors recommended acupuncture, cranberry juice, or other CAM therapies. However, the vast majority of CAM users did not report learning about remedies from their physicians.

Many CAM users mentioned learning about these therapies from friends and family in other countries, and attributed their use to the cultures to which these respondents belonged. Study participants reported that they either learned about these treatments when they resided in another region of the world or from relatives currently residing in those regions who sent the remedies to them. For example, one Hispanic female (age 46, born in El Salvador) commented on her use of cat's claw and how she came to know and use this treatment: "They're things you learn about in El Salvador. Sometimes they send me some from there, and I take it. But it still doesn't make [the urinary incontinence] go away." Another Hispanic woman (age 44, born in the Dominican Republic) with frequency and urgency said: "I drink it [sun thistle tea] because it's from my country. It helps a little."

**Discussion**

The qualitative analysis of the use of complementary and alternative remedies to treat urinary symptoms revealed findings that extend beyond what has been learned from other studies. First, CAM use in this sample was slightly lower (24%) compared to the most recent national survey (39%) (Barnes et al., 2008) most likely because participants were asked about their use of CAM specifically to treat urinary symptoms. It is possible that had participants been asked about CAM use for a broader range of symptoms or use of CAM to promote overall well-being or general health, rates of CAM use may have been comparable with national estimates. Using CAM to prevent the onset of illness is very different than using CAM to treat a health problem.

Data from this study revealed differences in CAM use by race/ethnicity and gender when asked about use for urinary symptoms. Study analysis highlights the importance of contextualizing CAM use to particular conditions or purposes. In this study, African-American men were the most likely and Caucasian women were the least likely to use CAM for urinary symptoms. While this study is not meant to generalize to the broader population, and group differences must be interpreted with caution, it is still useful to note these patterns are different than those revealed by other
quantitative studies that have found greater use among Caucasian women. Difference in results may be explained by the specific focus on urinary symptoms, again highlighting the importance of contextualizing CAM use to particular conditions and purposes.

Many herbs and supplements reported by African-American and Hispanic respondents are not among the commonly recognized remedies for urinary symptoms, such as cranberry juice and saw palmetto. Study analysis contributes important insight into the full range of remedies used to address urinary symptoms and illustrates how these practices vary by race/ethnicity and gender. Cranberry juice and saw palmetto receive a great deal of attention, perhaps because these methods are the methods of choice among Caucasian women and men, who are members of the dominant culture in the U.S. However, the study reveals how a much wider range of therapies is currently used to relieve urinary symptoms. Use of remedies more commonly recognized, such as cranberry juice and saw palmetto, is more frequently seen among Caucasian men and women, while African-American and Hispanic men and women rely on a broader range of remedies, including flaxseeds, ginseng, barley, cinnamon, and moabi, and other herbs, juices, and substances.

Based on findings from other studies, researchers suggest that racial and ethnic minorities use CAM for different reasons than Caucasians. For example, Graham et al. (2005) found that Hispanics reported using CAM because conventional treatments were too expensive. Findings from this study suggest culture and information from family and friends have an important influence on CAM use. Not only did family and friends tell participants about these remedies, they often supplied them, even sending them from another country. This latter point illustrates the influence of culture on information sharing as well as providing instrumental assistance. This was most apparent among Hispanics in this study, most of whom were born in different countries. Health professionals need to know about this full range of remedies and potential reasons for their use in the populations they are treating. It appears many CAM users learn about these remedies through social support networks rather than from their primary care provider.

Both African-American and Hispanic respondents referred to other non-American cultures or countries from which they learned about specific therapies. This is consistent with other research showing that the use of herbs and supplements is a cultural tradition among some racial and ethnic minority groups (Howell et al., 2006; Mackenzie et al., 2003). In this study, study participants born outside of the U.S. indicated using less commonly known remedies (such as moabi, cat’s claw, and maize silk). These findings are important for clinicians to consider if they intend to provide culturally sensitive care to all groups of patients in their practices. Lack of communication between patient and physician in the clinical setting about patients’ use of CAM is widely documented (Adler & Fosket, 1999; Herman, Dente, Allen, & Hunt, 2006; Sleath et al., 2001). In addition to concerns about the quality of the patient-physician relationship, such lack of communication may miss potential herb-drug interactions and may result in misunderstandings regarding treatment plans. In their study of communication of CAM use among Hispanic and Native American patients, Sleath and colleagues (2001) found that patients did not expect clinicians to be experts on CAM beyond having broad awareness of local types of CAM because patients understood that CAM is outside the training of most allopathic physicians.

Several points are worthy of consideration when interpreting these findings. This study provides only cross-sectional and self-reported data. It is possible these findings about CAM use could shift over time. Likewise, it is possible that individuals may not accurately recall CAM use in the past, which could distort the patterns reported here. However, the qualitative design of this study provides some degree of protection against these threats. By asking study participants to describe their use of CAM, better information about these practices was captured than simply asking if CAM was or was not used, an advantage of the qualitative design of this study.

An additional consideration is that this study population (BACH) is representative of the population of Boston, including a sample with the majority in middle and lower incomes. These characteristics may not be generalizable to other urban areas in the U.S. However, the lack of national generalizability should not diminish the clinical relevance of the findings presented here.

Conclusion

This study provides important evidence about a diverse range of remedies used to treat urinary symptoms and how patients use such remedies in relation to allopathic care. Clinicians can use these findings to enhance their communication with patients.

References
