Health beliefs and practices in a middle-income Anglo-American neighborhood

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ALTHOUGH THERE has been considerable literature addressing both the traditional and folk health beliefs and practices of culturally diverse peoples in the United States, little has been documented about the health beliefs and practices of Anglo-Americans. Studies concerning Hispanic-American health beliefs were done by Ailinger,[1] Clark,[2] Kay,[3] Lewis,[4] and Saunders;[5] Evaneshko[6] and Fuchs and Bashshur[7] have studied native Americans; Bloch,[8] LeMaile-Williams,[9] and Snow[10] have studied black Americans; Campbell and Chang[11] and McKenzie and Chrisman[12] have studied Asian Americans. In contrast, a study by Bauwens[13] is one of the few reported dealing with the health beliefs and practices of Anglo-Americans.

Many of the reported studies of culturally diverse peoples have described in detail the folk health beliefs and practices that were orally transmitted from generation to generation and that served to help the cultural group maintain health, prevent illness, or restore health following an ill-

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ness episode. According to Saunders, "folk medicine flourishes because it is a functional and integrated part of the whole culture, and because it enables members of cultural groups to meet their health needs, as they define them, in ways that are at least minimally acceptable."[14(p146)]

The extent to which folk health beliefs and practices permeate the Anglo-American culture and influence behavior with respect to health and illness is not clear. According to Saunders and Hewes,[15] folk and scientific medicine are interrelated in the Anglo-American culture. They contend that what probably distinguishes the systems is the "emphasis in scientific medicine on understanding cause and effect relationships . . . and the relative lack of such an emphasis in folk medicine."[15(p44)] Leininger refers to scientific health care as the "rational and systematic use of care and cure treatments based upon modern scientific methods of inquiry" and folk medicine as "empirically derived by a culture group through trial or long-term experiential means."[16(p48)] Mechanic notes that "folk beliefs persist in even the most modern nations, but they are very much submerged in countries with highly developed, scientific systems of medical practice."[17(p10)]

The extent to which folk beliefs and practices exist among Anglo-Americans but remain substantially undocumented in the literature has been a concern of the study investigators. An additional concern is whether folk health beliefs and practices are associated with income or socioeconomic class and, therefore, are less likely to exist among middle-income groups than among the lower-income Anglo-Americans studied by Bauwens in 1977.[13]

In the study reported here, data were gathered from residents of a middle-income Anglo-American neighborhood to determine (1) definitions of health, (2) health maintenance behaviors, and (3) illness beliefs and behaviors. The term *orthodox* refers to modern, Western, and scientific health care practitioners and practices. *Unorthodox* refers to health care practices of both laymen and marginal practitioners that may overlap with the orthodox system but have not achieved orthodox status.

THEORETICAL FRAMEWORK

Health, according to the biomedical model, is the absence of disease. At the other end of the spectrum, health is defined by the World Health Organization (WHO) as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[18] Definitions of health formulated in abstract terms cannot be applied to individuals. Dubos has noted the difficulty in applying any definition of health to a particular human being. Health for the marathon runner is not the same as for the pianist or the physically handicapped.[19] O'Connor and Ahmed visualize health as a holistic concept that is measurable according to each individual's ability and desire to engage in activities of their own choosing.[20] To determine a person's concept of health, an emic approach (that described from the individual's viewpoint) is more appropriate than an etic approach (outsider's viewpoint) if the goal is to understand how individuals foster health.

Folk health beliefs are usually orally transmitted from generation to generation and serve to help the cultural group main-

tain health, prevent illness, or restore health following an illness. Press has described folk medicine as "systems or practices of medicine based upon paradigms which differ from those of a dominant medical system of the same community or society."[21(p48)] Folk medicine endures because it meets the particular needs of the cultural group; it is characteristically pragmatic, and adaptive to change. As a society changes, new knowledge is generated that is first held only by the specialized professionals. It later filters down to the popular arena. In the degree to which new knowledge and concepts become common property, according to Eisenberg, "they may displace, merge, or simply coexist by the side of older lay beliefs, despite what appears to be logical incompatibilities."[22(p14)]

The lack of investigation of folk beliefs and practices of Anglo-Americans might be related to assumptions about health care that have only recently been challenged. Helman questioned the assumption that most people are familiar with and accept the biomedical model for defining and treating disease.[23] That biomedicine provides the only pathway to health has also been refuted by Weidman.[24] Press has challenged the viewpoint that there is only one paradigm of health and healing.[21]

Self-care is a phenomenon that has likewise received little attention in the literature; it is a component of health care that is assumed to be present but regarded as a marginal phenomenon.[25] Levin et al. defined self-care as "a process whereby a lay-person functions on his/her own behalf in health promotion and prevention and in disease detection and treatment at the level of the primary health resource in the health care system."[25(p11)] To date, most primary health care studies have focused on the professional contributions and have excluded a consideration of the lay contributions. Yet studies indicate that two thirds of all persons experiencing an illness do not contact the orthodox system.[26] Diagnosis that an illness is present is first made by the individual, described and explained within a personal or cultural folk model, and usually dealt with by self-care.[23]

Most primary health care studies have focused on professional contributions, yet two thirds of all persons experiencing an illness do not contact the orthodox system.

Alternatives or supplements to self-care exist outside the domain of orthodox health care. Chiropractors, a purely American phenomenon according to Firman and Goldstein,[27] are considered to be marginal, yet are often successful in treating patients whom the orthodox system has failed. The chiropractic model appeals to people for several reasons: (1) Chiropractors are empathetic to the patient's complaints; (2) they explain the problem in concise, anatomical terms; and (3) they offer hope of alleviating the problem. Their fees are often lower than those of orthodox physicians, and as a result they attract a larger segment of the lower socioeconomic group. The psychosocial support that chiropractors offer their clients has been a significant variable influencing their success.[27]

Other marginal providers likewise emphasize the holistic approach; provide detailed, understandable explanations of

the problem and the treatment; and allocate sufficient time to interact with the client. According to Fabrega and Zucker, during episodes of illness people will select various providers, depending on the systems of care available, what they believe to be their illness, and what outcomes can be expected by seeking a specific provider.[28]

STUDY METHODOLOGY

The target population of middle-income Anglo-Americans was identified on the basis of statistical data obtained from the San Diego 1975 Special Census.[29] The statistical area chosen was an area in metropolitan San Diego where the median income was $12,090 and the percentage of white population was 92.69%.

A convenience sample of 100 individuals 18 years of age or older who were of European ancestry and born in this country comprised the study sample. Nurses and physicians were excluded from the study, as were households with annual incomes less than $7,000. Forty-seven percent of households had annual incomes between $7,000 and $17,999; an additional 30% had incomes ranging from $18,000 to $25,999, and the remaining 23% had incomes above $26,000. When social class was determined using Hollingshead's two-factor index of social position,[30] 87 interviewees (87%) resided in middle-class households, classes II, III, and IV on the five social class scale. The two-factor index is composed of an occupational scale and an educational scale. In this study, social class was based on education of interviewee and highest occupational level within the household.

Of the individuals interviewed, there were 29 males and 71 females. Ages ranged from 18 to 88, with 28 (28%) falling within the 18-29 range, 55 (55%) in the 30-64 range, and 17 (17%) in the 65-88 age range. Ninety-one individuals (91%) completed high school; of those completing high school, 34 (34%) completed 1-3 years of college, and 19 (19%) completed 4 or more years of college.

Parents of informants were predominantly American born. Only 10% reported that both parents were born in Europe. An additional 14% reported one parent born in Europe.

Health care was usually sought from private physicians (63%). Twenty-three percent belonged to health maintenance organizations, utilizing services of a nurse practitioner or physician. The emergency department was reported as the usual source of health care for 11%. Community clinics and chiropractors were utilized with equal frequency (6%). Facilities for military personnel were utilized by 5% and student health services by 1%. Two percent reported nonutilization of health services. Payment for health care was predominantly by private insurance, followed in order of frequency by prepaid health plans, military benefits, Medicare, and out-of-pocket (either solely or in combination with one or more of the above payment sources).

A survey design was used to explore a broad range of health beliefs and practices. Taped interviews were conducted by the investigators in the homes of the subjects during the month of June 1979. Interviewing was done at varying times of the day and on different days of the week to obtain a demographically varied group of adult residents in the area. The interview guide was patterned after that used by Bauwens

in a study of health beliefs of low-income Anglos.[13] Both closed and open-ended interviewing techniques were used in obtaining data on where health care was obtained; beliefs about health and actions taken to maintain/restore health, recent ailments and actions taken to remedy them, and knowledge of causation of selected illnesses.

INTERVIEW RESPONSES

Perceptions of health status

Individuals were asked to rate their health as good, fair, or poor, and define what they meant by their rating. Eighty-five individuals rated their personal health as good, 11 as fair, and 4 as poor. The high "good health" response rate might be related to the income, education, and health care utilization characteristics of the sample. In a study by Carlton of residents of southeastern Kentucky, where the median educational level was approximately eighth grade and where 67% of the sample earned less than $5,000, only 36% rated their own or their spouse's health as good.[31]

The descriptive terms used in defining good health and whether the statement was mentioned first, second, or third in the individual's narrative response are shown on Table 1. Absence of sickness was mentioned by 57 individuals in the definitions of good health, with most of the respondents identifying at least two dimensions in their definitions. This finding corresponds to Baumann's study of the health conceptions of low-income clinic patients and medical students. This study also documented the lack of a single orientation to health.[32] Typical of the multidimensional statements made in the present study by individuals reporting good health were:

- "Having no major illnesses. There is nothing major or minor wrong with me that I know of. I take no medications."
- "Very rarely sick. Except for the fact that I smoke and I'm short-winded, I'm in good shape. Strong."
- "I don't wake up with aches and pains every day. I don't have to go to the doctor except for my yearly female physical."
- "I'm the type of person that never gets sick. Physically I'm very active. At age

Table 1. Definitions of good health

Description of good health	First response	Second response	Third response	Total
Absence of sickness	50	4	3	57
Feel good	21	13	1	35
Have energy	8	12	6	26
Able to work	5	11	2	18
Few doctor visits	9	5	1	15
No pain	2	4	1	7
Other	5	9	5	19

$N = 100$.

40 I jog 3-5 miles every day. I generally feel well."

It is obvious that these definitions lack the abstract character and positive focus of the WHO definition of health. One respondent came close, but in more concrete terms, in describing the biopsychosocial nature of health: "Good health is good mental health, good eating habits, good personal hygiene, good work habits, balance of work and recreation, and ways to relieve tension and stress."

Positive though the WHO definition is, it does not include the words *perfect* or *complete* health. Perhaps the respondent was defining good health in personal terms, realizing that "in the living there is no such thing as complete health any more than there is complete disease (which is death)."[33(p638)] Dubos speaks of the mirage of health and of the difficulty of formulating a definition of health broad enough to fit the jogging enthusiast, the migrant laborer, the sedentary scholar, and the physically handicapped.[19] Is then the real measure of health "the ability of the individual to function in a manner acceptable to himself and to the group of which he is a part?"[19(p261)] Several of the respondents felt their health was good because they were able to function adequately despite various diseases.

- "Considering the circumstances, I think it's good. I've had a heart attack, cataract operations in both eyes, and a stroke. So the fact that I get around at all, I'd say I have good health."
- "The things that might inconvenience me are not disabling and I can cope with almost all of them. I don't have colds or catch the flu. The only problem is an ongoing diarrhea that I think is all emotional and doesn't upset me that much."
- "The doctor says I'm not [in good health], but I think I'm in good shape, able to do what I want to do and get around." [This person reported a problem with her red blood cells "being eaten " and requiring a transfusion.]
- "I have high blood pressure, but outside of that I'd say it's good. I can do almost anything I want as long as I take my blood pressure medication."

Those who perceived their health status as fair or poor (15 individuals) felt that they deviated from good health on the basis of illness, frequent physician visits, inability to work, and experience of pain. Ten of these (67%) made their rating of fair or poor health on the basis of one or more diseases. The following comments illustrate perceptions of those in the study group who rated their health as fair or poor on the basis of disease states:

- "I'm under doctor's care all the time. I have urological problems, lots of trouble with chemistry imbalance."
- "Fair health means I'm not constantly ailing. I have asthma, glaucoma, arthritis, but I'm still active."
- "I'll run off a list of things wrong with me. I'm a diabetic, I have narcolepsy, I have bad circulation due to hardening of my arteries. I'm prone to skin cancer—I've already lost a piece of my ear."
- "I've had two coronaries, I'm hypertensive, and I have arthritis. If you didn't have any chronic illnesses and were able to function in society, you'd be in good health."

One individual who rated her health as fair deviated from the traditional disease

One individual who rated her health as fair deviated from the traditional disease orientation.

orientation, stating, "My health is not good because I do smoke and I could use more exercise and I could spend more time out in the fresh air."

Illness beliefs and behaviors

Knowledge of illness causation in this predominantly middle-income, middle-class sample of the population differed from what Bauwens found in a lower-income Anglo-American study. "The causes of illness are diffuse and generalized—climatic changes and impurities being the most often mentioned. There is little understanding that specific micro-organisms cause specific illness . . . that the measles virus causes measles, for example."[13(p246)]

In the present study, 96 individuals believed that illness can be caused by viruses or bacteria. Poor eating habits ranked a close second, with 93 responses. Seventy-five felt that drafts, cold air, and environmental fluctuations were causative factors. Belief in hexes or witchcraft as causes of illness was held by 24. Seventeen believed that illness could be a result of punishment from God. Stress was mentioned most frequently in response to the open-ended question, "Do you think there are other causes of illness?"

Although 96 individuals believed in the germ theory of disease causation, they were less likely to cite orthodox belief when asked to specify the causes of selected health problems. On the one hand, they cited impurities of the blood stream as the cause of boils; "nerves" as the cause of shingles; and drafts, cold air, and temperature fluctuations as the cause of colds. On the other hand, they associated viruses with measles, heredity and diet with diabetes, and stress and obesity with hypertension.

Fifteen individuals reported having no ailments or injuries during the preceding year. Of the 85 reporting one or more ailments and/or injuries, the problems that occurred in at least 10% of these individuals were as follows: 37% had upper respiratory infections, 15% had musculoskeletal problems (sprains, strains, bursitis, and backache), 12% had skin problems, 11% had hypertension, and 11% had arthritis.

Of those reporting an ailment or injury incident, 31% stated that they did not consult anyone for advice about their problem. It is tempting to infer that these individuals either engaged in self-treatment or ignored the ailment or injury; however, such inferences might be unwarranted. No data were collected to determine if the reported incidents were first-time occurrences or recurrences of previously encountered problems for which advice from health care providers might have been sought.

When individuals in the study group perceived themselves as ailing or injured and went beyond self-treatment, 70% reported going directly to the physician for advice rather than through a lay-referral system. As the focus of this study was not on the lay-referral system, data were not adequate to make meaningful inferences.

In addition to being asked to recall those ailments or injuries experienced during the previous year, individuals were presented

with a list of symptoms or conditions commonly encountered. If they indicated having the symptom or condition during the past year, they were asked, "What did you do for the condition?" Self-treatment for common health problems was prevalent, as evidenced by self-treatment for constipation (90%), headaches (75%), piles or hemorrhoids (70%), and sore throat and/or runny nose (78%) (see Table 2). Media advertisements for a variety of self-care modalities for the symptoms listed might have been a factor influencing self-care.

In contrast, there were conditions for which individuals tended not to self-treat, such as high blood pressure (5%), lump (9%), and unexplained weight loss of 10 pounds or more (14%). Perhaps current media campaigns informing the public of cancer warning signs and the need for early diagnosis and treatment of high blood pressure influenced respondents' decisions not to self-treat.

Health maintenance activities

Popular literature dealing with health (how to get it or keep it by following this-or-that diet, doing this-or-that exercise, or reducing stress by this-or-that method) abounds on bookstore and supermarket shelves. Table 3 indicates the frequency with which study participants selected activities or behaviors to keep their health.

Table 2. Self-treatment for symptoms and conditions

Symptom/condition	Number of individuals who reported problem	% who self-treated
Constipation	20	90
Sore throat, runny nose	45	78
Frequent headache	20	75
Piles or hemorrhoids	17	70
Temperature over 101°F	16	62
Cough for several weeks	19	51
Diarrhea	37	54
Backache fairly often	20	45
Indigestion	24	45
Arthritis	25	44
Feeling tired all the time	16	43
Severe shortness of breath	9	33
Feeling of dizziness	28	32
Inability to sleep fairly often	19	31
Rash or itch for a week or more	22	31
Discolored patches of skin	26	19
Unexplained loss of weight of 10 lbs or more	7	14
Lump	11	9
High blood pressure	20	5

$N = 100$.

Table 3. Health maintenance activities

Activity/behavior	First response	Second response	Third response	Fourth response	Fifth response	Total
Diet/nutrition	41	17	15	2		75
Exercise	27	22	6	2		57
Vitamins	7	21	14	6	1	49
Rest	4	11	5			20
Work/activity	9	5	3	2		19
Meditation/positive thinking	4	1	2	2	2	11
Health foods		3		2		5
Herbs			1	2	1	4
Nothing	4					4

$N = 100$.

Diet, exercise, and vitamins were the predominant measures taken for maintaining health. The relationship between diet and health was verbalized by three fourths of the respondents, with a focus on a balanced diet and avoidance of foods claimed "not good for you," such as heavily processed food, sugar, salt, red meat, and "junk" food. Comments included:

- "Things I suppose most people do ... I try to put balanced meals on the table, maybe not balanced every meal, but throughout the week. We've never skimped on meals. My husband feels that if you eat properly you pay less doctor bills."
- "The more natural things you are into the better. We don't eat any meat here hardly at all; fresh fish or chicken and lots of vegetables and fruits and nuts. I try to keep as natural as I can. I don't buy candy; I buy sunflower seeds."
- "I try to cut out a lot of sugar, white flour, and junk food. I've cut out beef lately, and I've found that I feel better. (I take) multivitamins with minerals because from what I've read I feel I need them. I really don't exercise, but I have been dieting. To me that would seem to help me out a lot toward good health."
- "I drink lots of water, eat healthful foods, eat plenty of vegetables and fruit, drink orange juice, and stay away from carbonated drinks. I drink decaffeinated coffee and fruit juices, but mostly water."

When asked specifically about health foods, individuals listed fruits, vegetables, whole grain cereals, and breads. Typically, health foods were defined as foods that are healthy for you to eat, not necessarily something one goes to a health food store to purchase. Specialty products from health food stores were considered by many as too expensive and not needed if a well balanced diet was eaten.

Vitamins were taken sporadically to ward off illness or as a form of treatment for specific problems. Like specialty health foods, they were considered too expensive to purchase indiscriminantly. Multivitamins were the most popular, followed by

vitamins C, B, E, and A in descending frequency. The reasons for taking or not taking vitamins varied:

- "I take vitamins, but not regularly. If I have been sick or if a member of my family is sick I put them on vitamins to help because I feel that the resistance is down at that point and this is when they need extra vitamins. Vitamin C used when a cold is coming on."
- "This may sound crazy, but vitamin E for extra oxygen in my blood because I'm a heavy smoker and sometimes I get kind of, I describe it as cobwebs in my brain, kind of fuzzy. Vitamin E seems to help that."
- "Vitamin E for your monthly period. It's supposed to help you so you don't get blood cramps."
- "Take vitamins sporadically. It goes through phases of people I hang around with . . . if they're vitamin freaks they get me into it, but the vitamins are pretty expensive. Good vitamins are expensive and store vitamins don't seem to be good because they've been sitting on the shelves too long. It's pretty expensive to take vitamins and if you eat right and take care of yourself you really don't need them."

Over 50% mentioned exercise as a means of staying healthy. Some were jogging enthusiasts; others were walkers, swimmers, dancers, and gardeners. Few respondents felt obligated to offer an excuse for not exercising. Four percent admitted doing nothing to keep their health. Those mentioning exercise in greater detail went on to explain:

- "I take a walk just about every day and go up a steep hill. If for any reason I can't go for a walk, I jump rope."
- "I take aerobic dancing and swim. I like to walk. Outside of that, I don't do anything."
- "Jogging has a lot to do with it [keeping healthy]. I've been jogging for two years and I've noticed that since I've been jogging it makes a lot of difference in my health" [jogs 2-5 miles every day].
- "I run three miles four times a week, play golf, and swim."
- "I walk a mile intermittently, garden, and bike."

An eclectic approach to maintaining health was favored by many. This group described various activities of daily living, such as working, keeping busy, resting, playing, and eating well, with no one activity receiving particular attention.

Maintaining adequate bowel functioning was associated with health by both the young and the old. An 88-year-old attributed his longevity to

- "keeping my bowels open. I take Milk of Magnesia and one-half glass of hot water every morning. My brother recommended I use this."

A 19-year-old stated:

- "Keeping your elimination good. I

An eclectic approach to maintaining health included various activities such as working, keeping busy, resting, playing, and eating well, with no one activity receiving particular attention.

Table 4. Home remedies reported

Symptom/condition	Remedies employed
Cough and colds	Mixture of orange, grapefruit, lemon, and lime juice taken at onset of cold
	Syrup of whiskey and honey
	Syrup of honey, tea, and lemon
Gastric problem	Ginger tea for stomachache
	Lecithin for indigestion
	Buttermilk
	Warm chocolate milk
	Mixture of ⅔ c orange juice, 1 tbsp each of salt and sugar, ⅓ c water
	Baking soda, hemp, and papaya tablets for nausea
Diarrhea	Alfalfa tea
Constipation	Spearmint tea
Burns	Aloe vera plant
	Constarch or baking soda
	Cold tea applied to sunburn
	Tea application, followed by vitamin E ointment (secret family recipe)
	Butter
Cleansing the blood	Vinegar
	Ginseng
	Family remedy
Tooth problem	Oil of cloves for aches
	Gargle of myrrh and golden seal to tighten loose tooth
Low energy	Oatmeal water
	Spearmint tea
Nerves	Catnip tea as a natural tranquilizer
Aches and pains	Laying-on of hands
	Aspirin soak if extremity is involved
Arthritis	Wear copper bracelet
	Cod liver oil
Flea bites	Take garlic and milk
	Vitamin B-12
Lung problems	Cayenne pepper
	Horehound, colts foot, golden seal, myrrh, mullein, and cayenne for bronchitis
	Mustard plaster for pleurisy
	Avoid flesh foods, eat raw foods, take garlic, pollen, manganese for asthma
Rash or boils	Cornstarch paste for rash
	Skin of an egg or Barbasol cream for boils

think that's really important because your colon is kind of your life line. If that gets congested and clogged up, you're going to start to have problems. Every once in a great while if I really have some problems I go to a woman (MD) named _____. She gives colonics. I've been to her twice. Every morning I try to have a mixture of oatmeal and bran with a banana and oil and honey. I think that's really good. It keeps me regular."

Patent medicines and home remedies

Patent medicines were as available in the homes of this middle-income Anglo group as they were in the lower-income Anglo group studied by Bauwens.[13] Possession of patent medicines by the middle-income group was assumed to relate to self-treatment of the commonly reported ailments or symptoms. Ninety-two respondents said they kept aspirin or similar medicines in their homes, 85 had skin preparations available, 69 had vitamins, 45 had rubs of some kind, 44 had Alka Seltzer® and similar preparations, 27 kept minerals on hand, and 23 had laxative preparations.

Folk remedies have existed through the ages and have been widely reported in the literature, although no studies have reported on folk or home remedies utilized by middle-income Anglo-Americans. A limitation of the present study was that contact with the subjects consisted of one interview. Some individuals might have been hesitant to admit unorthodox practices to strangers. Nevertheless, 36% reported using home remedies, and 12% reported using herbs and plants. Use of folk medicine was unrelated to age.

- "Vinegar is good for cleansing of the blood" (38-year-old).
- "I used Ginseng for blood purification for one month, then quit as I noticed no change" (23-year-old).
- "Catnip tea is a good natural tranquilizer" (48-year-old).
- "Use an ointment that daughter-in-law makes, don't know the ingredients because she won't tell me. It's an old family recipe for burns, boils, and insect bites" (66-year-old).
- "I used myrrh and golden seal to gargle with to tighten a loose tooth; it worked" (34-year-old).
- "I take garlic capsules (2 per day) for high blood pressure. I read about it in *Prevention Magazine*" (59-year-old).

One individual not using herbs stated she might consider their use because "for many more years than there has been written history, man managed to use herbs and teas to cope with his illnesses" (61-year-old). Table 4 lists the home remedies used by the study population.

Health literature

A plethora of books and magazines dealing with health-related topics is available for lay persons. To what extent are they referred to for health and illness information? Koos reported that "family doctor books" were used more frequently by farm families (18%) than by nonfarm families (2%).[34] In the more than 25 years since this study, the mass media has become a major source of information on becoming informed participants and consumers of self-care.

In this middle-class sample, at least one written source dealing with topics of

health or illness was used by 57% of the respondents. References on health-related topics slightly out-numbered references dealing with illness. The level of sophistication as well as the focus of sources varied considerably. Family doctor books have been replaced by the *Harvard Medical Newsletter* and the *Medicine Show*. Books on general health and medical encyclopedias by *Better Homes and Gardens, Time/Life, Reader's Digest, Good Housekeeping,* and others were mentioned. Other more medically oriented references included *Merck Manual, Physicians' Desk Reference,* and medical dictionaries. Literature focusing on health was most widely represented by books on nutrition, and ranged from Jethro Kloss and Adele Davis to Dr. Atkins and Eddie May. *Prevention Magazine, Mother Earth News, Holistic Health,* and of course Dr. Spock were represented.

Role of the pharmacist

The role of the pharmacist in providing a wide range of health services is well documented in the professional literature. Standards of practice for the pharmacy profession include much more than the obvious preparing and dispensing of prescriptions.[35] Support of these standards is found in literature describing the role of the pharmacist in helping people select over-the-counter drugs, in educating consumers about medications, in providing information on exercise precautions, and in treatment and referral.[36-39] Both Koos and Bauwens found that the pharmacist plays a significant role in advising, diagnosing, and recommending treatment for lower-income individuals.[13,34]

Forty-nine percent of the study participants consulted the pharmacist for advice about treatment for conditions perceived as "nothing very serious," such as hemorrhoids, coughs, colds, and skin rashes. In addition to inquiries about common health problems, pharmacists were asked for information about medications prescribed by a physician:

- "My husband was given some medicine and we were curious what is in it, or if there were side effects."
- "Whenever a doctor prescribes something and I don't know what it is, I check it out. I don't trust his [the physician's] judgment."
- (I ask) "about medicines prescribed for any member of my family, what are the precautions for taking it before or after meals. Lots of times it isn't put on the prescription" (label).

Alternative providers

Alternatives to orthodox practices were sought by relatively few respondents, though types of practitioners consulted included chiropractors, acupuncturists, herbalists, nutritionists, iridologists, and spiritualists.

- "I'm going to an iridologist for a weight problem."
- "A year and a half ago I would not have considered a chiropractor. After $9,000 and no relief, on the advice of someone from the university, I went to a chiropractor. This guy really helped me."
- "I read numerous books which I bought at the health food stores, and I consult nutritional advisors."
- "If I knew an herbalist or nutritionalist

that knew his stuff, I'd go. I have faith in them."

- "I'm toying with the idea right now [for my arthritis] of seeing an acupuncturist. The lady up the street went, had four treatments, and is back bowling again."

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Eighty-five percent of the middle-income Anglo-American study participants felt they were in good health; absence of sickness (even when clearly defined disease processes were present) was the criterion most frequently applied in defining personal health status. Definitions lacked the abstract character of the WHO definition of health. Consuming balanced meals by avoiding heavily processed foods, sugars, and junk food and consuming more natural foods such as fresh fruit and vegetables was the most important consideration in maintaining health. For this group, specialty vitamins were considered too expensive to purchase indiscriminantly; therefore, multivitamins were used. Exercise ranging from jogging to gardening was part of the repertoire of activities engaged in to maintain health.

Orthodox and unorthodox beliefs and practices coexisted in the study population and influenced self-care as well as seeking outside sources of care. A wide variety of over-the-counter medications and folk remedies were employed for self-treatment of common health problems. Individuals who went beyond self-treatment generally sought care from orthodox Western practitioners. Nearly half (49%) of the study participants consulted pharmacists about treatment for problems perceived to be self-limiting and for advice and clarification of the action and side effects of prescribed medication. These findings support Fabrega and Zucker's belief that during episodes of illness people will select various providers.[28]

The findings of this exploratory study cannot be generalized to other middle-income Anglo-American populations due to the fact that participants were obtained nonrandomly from a limited geographic area. Reasons why some households participated when the investigator knocked on their door and others declined to participate are unknown. Another limitation was the one-time interview during which respondents might have been reluctant to disclose unorthodox beliefs and practices. Nevertheless, study results suggest implications for the practice of nursing and areas for future research efforts.

Even though data are inconclusive as to the pervasiveness of Anglo-American health care beliefs and practices that are outside of the biomedical paradigm, it seems appropriate for nurses to be attuned to the possibility of their existence. Data collection tools and interviewing strategies developed for use with culturally diverse peoples might be equally useful in determining unorthodox health beliefs and

Blending unorthodox practices with scientific practices might be more beneficial to clients than attempting to displace beliefs and practices that are not clearly harmful in light of existing scientific knowledge.

practices of Anglo-Americans. Nursing interventions that focus on blending unorthodox practices with scientific Western practices might be more beneficial to clients than attempting to displace beliefs and practices that are not clearly harmful in light of existing scientific knowledge.

Future research that focuses on studying fewer variables over time, as opposed to the one-time interview used in this exploratory study, is recommended. Suggested areas for study include (1) usage patterns of patent medicines in self-treatment, (2) usage patterns of home and/or folk remedies in both the search for health and alleviation of sickness, and (3) the process engaged in for self-perceived deviations from the normal health state.

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