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Ethnic Differences in Complementary and Alternative Medicine Use among Patients with Diabetes

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Abstract

Objective—To evaluate the effect of ethnicity as a predictor of the use of complementary and alternative medicine (CAM) among patients with diabetes.

Design and Settings—A 16-item questionnaire investigating CAM use was distributed among patients attending the Taking Control of Your Diabetes (TCOYD) educational conferences during 2004-2006. Six TCOYD were held across the United States. Information of diabetes status and sociodemographic data was collected. CAM use was identified as pharmacological (herbs and vitamins) and nonpharmacological CAM. (e.g., prayer, yoga, and acupuncture).

Results—The prevalence of pharmacological and non-pharmacological CAM among 806 participants with diabetes patients was 81.9% and 80.3%, respectively. Overall, CAM prevalence was similar for Caucasians (94.2%), African Americans (95.5%), Hispanics (95.6%) and Native Americans (95.2%) and lower in Pacific Islanders/Other (83.9%) and Asians (87.8%). Pharmacologic CAM prevalence was positively associated with education ($p = 0.001$). The presence of diabetes was a powerful predictor of CAM use. Several significant ethnic differences were observed in specific forms of CAM use. Hispanics reported using frequently prickly pear (nopal) to complement their diabetes treatment while Caucasians more commonly used multivitamins.

Conclusions—Treatment with CAM widely used in persons with diabetes. Ethnic group differences determine a variety of practices, reflecting groups' cultural preferences. Future

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research is needed to clarify the perceived reasons for CAM use among patients with diabetes in clinical practice and the health belief system associated with diabetes by ethnic group.

Keywords

complementary and alternative medicines; diabetes; ethnicity

Introduction

The use of complementary and alternative medicine (CAM) has increased significantly over the last two decades.¹⁻⁴ The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as “healthcare and medical practices that are not currently an integral part of conventional medicine.”³⁻⁵ A 2004 report revealed CAM prevalence as 64% in the general United States population when prayer is included and 36% when prayer was not included in the definition.³ Commonly used CAM are herbal therapies, multivitamins, prayer, acupuncture, yoga and aromatherapy, among others.^{4, 6-8}

Patients with chronic conditions such as cancer, arthritis, asthma, hypertension, and diabetes are more likely to use CAM than the general public.^{1,2,4,9} Although patients do not necessarily use CAM to treat their primary chronic illness, more than 50% percent believe the CAM helps their overall health.

Many patients with diabetes use CAM in an attempt to obtain better glycemic control, reduce their diabetes complications and/or to supplement their current diabetes medication.⁶ However, few studies exist that analyze the prevalence and types of CAMs used in diabetes. Prior evidence of the prevalence of CAM use in persons with diabetes ranges from 8% to over 45%.⁷ The studies available are confined to specific geographical areas and subpopulations and are not representative of the more than 23 million people in the US with diabetes.^{6, 7} Moreover, there is limited evidence of CAM use across different ethnic groups and the specific factors which predict CAM use in patients with diabetes. Results from an analysis of the 1996 Medical Expenditure Panel Survey found Hispanics and African Americans in the general population were less likely to use CAM compared to Caucasians;⁴ however, in individuals with diabetes there was no significant difference in CAM among these three racial/ethnic groups. Over-sampling of Hispanics and African Americans may have altered these findings, and results may not be representative of the national population.

Conversely, a study by Schoenberg and colleagues¹⁰ contained an equal number of Native American, Hispanic, African American, and Caucasian patients. Results showed that Hispanics had a higher CAM use (40%) than African Americans (20%), Native Americans (15%), and Caucasians (15%). Among all the ethnic groups, CAM use was associated with their ethnic and cultural background. Other studies report lower prevalence of CAM use among African Americans compared to other ethnic groups.²

In our study, we investigated the effect of sociodemographic variables in predicting CAM use among individuals with diabetes from six ethnic groups attending an educational conference during 2004-2006.

Materials and Methods

A 16-item, anonymous questionnaire on CAM use in diabetes was distributed to all persons attending “Taking Control of Your Diabetes” (TCOYD) conferences throughout 2005-2006. The questionnaire's content was developed from previously published CAM questionnaires^{7, 8, 11} and the results from two focus groups. Those focus groups sessions were held in 2004

and twenty-one participants with diabetes responded to questions regarding the role of CAM use in their diabetes care. Participants reported their frequency of CAM use, reasons for CAM use, and the specific types of pharmacologic and non-pharmacologic CAMs used.

Established in 1996, TCOYD is a not-for-profit 501(c)3 charitable organization that aims to educate and empower individuals with diabetes and caregivers of diabetes patients to take charge of their health care.¹² Approximately six to ten TCOYD conferences are held across the United States annually. TCOYD conferences provide medical education and motivational lectures on diabetes topics to people with the diabetes and their family members. The format for those conferences include a general session, disease specific workshops, and hand-on sessions where patients can discuss their diabetes and related disorders with health care professionals. This model was recently recognized as an appropriate model for diabetes education by the American Diabetes Education “Outstanding Education Award” presented to Dr. Steven Edelman at the ADA's 69th Scientific Sessions in New Orleans on June 8th, 2009.

CAM and diabetes questionnaires were distributed at the conference registration booth, and participants were encouraged to complete them during each TCOYD conference. Questionnaires were collected in six cities across the United States in 2004-2006: San Diego, CA; Amarillo, TX; Hilo, HI; Raleigh, NC; Des Moines, IA; and Santa Rosa, CA. The questionnaire contained demographic information (age, gender, education, household income), number of oral medications used, insulin use, prevalence and types of diabetes complications, types of CAMs used during the last 12 months, reason for use, and if the patient reported CAM use to a physician.

CAM use was divided into two categories: pharmacologic (e.g., herbs and supplements) and non-pharmacologic (e.g., prayer, yoga, aromatherapy, and visiting a medicine man/woman). These two categories include three of the four major types of CAM determined by the NCCAM.⁵

Patients self-identified their ethnicity by answering if they were Anglo or Caucasian, African American, Hispanic or Latino, Asian, Pacific Islander or other. The study was reviewed and approved by the UCSD Institutional Review Board. Statistical analysis was performed in STATA 9.0 (StataCorp LP, College Station, TX). Tests performed included binary logistic regressions, Pearson's χ^2 tests and Fischer's exact tests, when expected frequencies were less than five. A p-value of less than 0.05 was considered significant. Using Caucasians as the controls, odds ratios were used to determine if there were differences in individual CAM use among ethnic groups.

Results

CAM Use and Sociodemographic Status

Of 931 participants, 806 (86.6%) had diabetes confirmed either by being told by a physician, taking medications for diabetes, or by the diagnosis of a diabetes complication. Table 1 shows participants were predominately male (71.4%), middle age (56.8 ± 0.44 years) with some college (59.1%), and had an income greater than \$30,000 (62.4%). Caucasians were the largest group (56%), followed by Asians (12.3%), Hispanics (11.3%), Native Americans (7.9%), Pacific Islanders/Others (7.0%), and African Americans (5.5%). More than two-thirds of the responders (69.1%) were currently taking oral medications for their diabetes, and one third (35.7%) reported diabetes complications (retinopathy, neuropathy, amputations, or macrovascular complications). Diabetic retinopathy was the most common complication (22.2%) followed by cardiovascular (11.6%) and diabetic foot (14.8%). Almost all of the participants (96.2%) saw a physician regularly, and 72.5% reported their

physician was aware of their CAM use independently of ethnicity. Nonetheless, physicians of Hispanic patients were nearly four times less likely to know of their CAM use compared to Caucasians patients [OR = 0.27, (95% CI: 0.14, 0.54)].

The prevalence of any form of CAM use in patients with diabetes was 92.9%. The prevalence of use of non-pharmacologic and pharmacologic CAM therapies was 80.3% and 81.9%, respectively. The most common non-pharmacologic CAM were exercise (66.8%) and prayer/meditation (35.9%). The most common pharmacologic CAMs were multivitamins (45.3%), Vitamin E (35.7%), and green tea (30.9%). (Table 2).

There were no significant differences in CAM (pharmacologic or non-pharmacologic) use when controlled by age, income, or gender groups. Pharmacologic CAM use was positively associated with education level. Individuals with more than high school education were significantly more likely to use pharmacologic CAM ($\chi^2 = 14.1$, $p = 0.001$). The distribution of pharmacologic and non-pharmacologic CAM use by ethnicity is presented in Tables 3 and 4. African Americans had the highest prevalence (84.1%) and Asians had the lowest prevalence (70.4%) of non-pharmacologic CAM use (Table 4). African Americans, Hispanics, and Asians reported the highest rate (approximately 95%) and Pacific Islanders/Others reported the lowest rate (83.9%) of any form of CAM use.

Pharmacologic CAM Use and Ethnicity

We further examined ethnic differences with respect to specific forms of CAM use. Table 3 shows significant ethnic differences were found in the prevalence of pharmacologic CAM therapies ($\chi^2 = 13.3$, $p = 0.02$) and any CAM use ($\chi^2 = 13.9$, $p = 0.02$). Hispanics had the highest prevalence (85.6%) and Pacific Islanders/Others had the lowest prevalence (66.1%) of pharmacologic CAM use. There were significant differences in the reported use of American ginseng, ginkgo biloba, glucosamine, multivitamins, noni juice, prickly pear cactus and Vitamin E by ethnicity. To determine specific ethnic differences in CAM use, odds ratios were used with Caucasians as the control (OR = 1.0). Asians were 2.27 times less likely and Pacific Islanders/Other were more than three times less likely to use any CAM compared to Caucasians. Similarly, Pacific Islanders/Other were nearly three times less likely to use pharmacologic CAM compared to Caucasians. Native Americans were significantly more likely to use American ginseng and aloe vera compared to Caucasians. Hispanics/Latinos were approximately five times less likely to use chondroitin sulfate and glucosamine compared to Caucasians. Asians reportedly used significantly less garlic than Caucasians. Other ethnic groups were two to five times less likely to use multivitamins compared to Caucasians. Noni juice was used most often by Pacific Islanders/Other and they were four times more likely to use noni juice than Caucasians. Prickly pear cactus (nopal) was used almost exclusively by Hispanics. Caucasians reported a significantly higher rate of Vitamin E use compared to Hispanics/Latinos, Asians and Pacific Islanders/Other. There were no significant differences in any specific CAM use between African Americans and Caucasians (Table 3).

Non-Pharmacologic CAM Use and Ethnicity

Table 4 shows there were also many significant ethnic differences with respect to use of non-pharmacologic forms of CAM. Asians and Native Americans were two times less likely to use non-pharmacologic CAM compared to Caucasians. There was a significant difference in chiropractic use between Other/Pacific Islanders and Caucasians. Use of a medicine man or woman was more than three times higher in Hispanics/Latinos and Native Americans compared to Caucasians. Healers were used almost exclusively by Native Americans. Native Americans were nearly 7.5 times as likely to use healers as Caucasians. African Americans reported the highest rate of prayer (43.2%). Prayer was significantly less likely in Hispanics/

Latinos than Caucasians. Caucasians were nearly seven times as likely to use acupuncture compared to Hispanics. Compared to Caucasians, Asians were significantly less likely to use relaxation as a form of non-pharmacologic CAM. There were no significant ethnic differences in the use of exercise, homeopathy, hypnosis, massage, physiotherapy, relaxation, a special diet, or yoga. (Table 4)

Participants reported that the primary reason for using CAM was that it made them feel better and/or stronger (77.2%). This was significantly higher than any other reported reason for using CAM ($p < 0.001$). Other popular reasons of CAM use included to control diabetes (69.9%), CAM effectiveness (68.4%), and to decrease blood sugar (64.6%). Participants with diabetes were least likely to use CAM to help other medications (44.6%) or because of the relative inexpensive cost of CAM (45.4%). Nearly 70% reported using CAM for its effectiveness (68.4%), to help control diabetes (69.9%), and to reduce blood sugar (64.6%). Controlling diabetes was the main reason African Americans and Hispanics/Latinos used CAM (72.2% and 78.6%, respectively). Asians principally used CAM to feel stronger (79.7%), for its effectiveness (79.7%), and to control diabetes (78.1%).

Predictors of CAM Use

Diabetes and education level were predictors of CAM use. People with diabetes were 2.5 times as likely to use CAM as people without diabetes [OR = 2.50 (95% CI: 1.45, 4.33)]. After controlling for ethnicity, participants with diabetes were significantly more likely to use CAM [OR = 2.2 (CI: 1.25, 3.95)]. People with at least some college education were 1.8 times more likely to use CAM [OR = 1.82 (95% CI: 1.20, 2.76)]; however, income and age were not significant predictors. After adjusting for education, age, income, and gender, diabetes was still a predictor of CAM use [OR = 2.37 (95% CI: 1.18, 4.77)]. However, diabetes was not a significant predictor of CAM use after adjusting by ethnicity [OR = 2.03 (95% CI: 0.98, 4.20)].

Discussion

Our study provides additional evidence on the high prevalence of CAM use among people with diabetes in the United States. Individuals who attended six national, educational conferences for people with diabetes reported in a multiethnic cohort a high use of both pharmacologic and non-pharmacologic CAM use regardless of age, gender, household income, time of diabetes diagnosis or diabetes complications. Previous reports of CAM use among adults with diabetes have shown prevalence rates from 48% to 72.8%,^{9, 13} but to our knowledge this is the first cross-sectional study analyzing CAM use differences among six different ethnic groups.

CAM use was higher among subjects with diabetes seeing a physician regularly and significantly higher among subjects with more education ($p = 0.001$). A prior study showed more educated individuals, adults ages 35-49 years, with household incomes of more than \$50,000 have reported more frequent CAM use (48.1% vs. 42.6%, $p = 0.03$).² Subjects with some college education had a 39% increase in CAM prevalence compared to those with less education (50.6% vs. 36.4% $p = 0.001$). The 35-49 age group and women were shown to have more frequent CAM use along with Caucasians and Western residents in a subsequent study.⁴

Our study also confirms the heterogeneity of CAM practices among subjects with diabetes. In this multiethnic sample, the use of pharmacologic CAM (multivitamins, glucosamine, ginkgo biloba, etc.) versus non-pharmacologic CAM (chiropractic, acupuncture, healer, massages) was similar across all ethnic groups. In our study, patterns of CAM use varied by ethnicity. For example, Caucasians reported more frequent use of multivitamins,

chiropractic, massages and prayer, whereas African-Americans reported more Vitamin E consumption and use of prayer as CAMs. The frequent use of multivitamins and supplements among Caucasian individuals and other economically secure groups with other chronic medical conditions among has been reported previously.¹⁴ The use of prayer as CAM among patients with diabetes is very common in the United States. Yeh and colleagues reported 45.9% of prayer use among 95 patients with diabetes in a national sample.⁷ Compared to this study, we identified a slightly lower rate of prayer use (35.9%), but similar rates of herbal remedies (19.2% vs. 16.2%) and healers (1.5% vs. 1.6%). Our study reports a higher prevalence of chiropractic, massage, aromatherapy, yoga and medicine man use in patients with diabetes, particularly among Native Americans.

A different diet was only reported by 22.5% (Asians) to 35.6% (Hispanic/Latinos) of participants with diabetes. One would anticipate individuals with diabetes to be on a special diet since it is a recommended guideline by the American Diabetes Association and the American Academy of Clinical Endocrinologists.^{15, 16} There may be an under-reporting for a special diet if the survey question was misinterpreted. Many may consider the Medical Nutrition Therapy associated with diabetes therapy to be standard care, not a “special” diet; thus, participants would not report a special diet as one of their CAMs used in the past 12 months. Alternatively, the low response rate may reflect how many persons with diabetes adhere to the Medical Nutrition Therapy prescribed or recommended by healthcare providers.

Hispanics reported a higher consumption of herbs (such as prickly pear cactus (*nopal*), aloe vera, or noni juice (*savila*)) and low use of supplements, multivitamins and glucosamine. Our study confirms this preference for oral herbs and remedies among Hispanics, particularly in low-acculturated groups had been documented previously.¹⁴ The use of herbs, teas, and other oral therapies in addition the use of curanderos, sobadores (massages) and healers play a role of in the culture and traditional health belief systems in folk medicine among Mexican-Americans and other Latino groups.^{17, 18} Hispanic patients with diabetes preferred pharmacologic CAM versus non-pharmacologic CAM in our study. Prickly pear cactus is frequently used among patients from this group have been for the treatment of diabetes because they believe this is a more natural and less expensive mode to complement their traditional diabetes treatments.¹⁹

Nonpharmacologic CAM use among Asians was similar to the rate of any CAM use reported by Asians in a 2006 study.²⁰ Asians were significantly more likely to use ginkgo biloba than Caucasians in both samples. Healers were also reported more often in Asians than Caucasians. Many Asian Americans incorporate traditional Eastern and folk medicine which reflect their spiritual beliefs and/or heritage.^{20, 21} Unlike other studies, our sample reported using CAM specific for its disease state.^{1, 2, 6, 9}

Some study limitations included the nature of a cross-sectional study and the survey did not elicit health belief systems among those who completed the survey. Nor did we differentiate between participants with type 1 and type 2 diabetes. Caution should be exercised in interpreting results when multiple comparisons are conducted. The high prevalence of CAM use among ethnic groups made it difficult to determine if ethnicity was a predictor of CAM use among diabetes patients. Because our sample was taken from diabetes conferences around the United States, our percent of participants with diabetes (86.6%) is significantly higher than that recorded by the Center for Disease Control and Prevention for the general population (7.8%). However, this sample gives a beneficial insight to the use of CAM in a diverse population of individuals with diabetes.

Conclusion

Across all age, gender, and income categories, CAM use is very common in patients with diabetes. Yet, we found the type of CAM varied by ethnicity. Predicting CAM use is multifactorial and healthcare providers need to be equipped to identify patients who will use CAMs and educate them on specific CAM safety and efficacy. In addition, healthcare providers should follow the CAM safety guidelines provided by the American Diabetes Association in order to optimize the current patient care available. Future research is needed to clarify the perceived reasons for CAM use in clinical practice and the perceived efficacy of such approaches as well as to determine their effect on metabolic control.

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Sociodemographic Variables**Table 1**

	N	%
Total Participants with Diabetes	806	86.6
Gender		
Male	574	71.4
Female	230	28.6
Age (years $\pm$ SD)	56.8 $\pm$ 0.44	
Age		
<30 years	20	2.5
30-45	107	13.4
45-60	320	40.2
>60	350	43.9
Ethnicity		
Caucasian	446	56.0
African American	44	5.5
Hispanic/Latino	90	11.3
Native American	63	7.9
Asian	98	12.3
Other/Pacific Islander	56	7.0
Income		
<30,000	257	37.6
30,000 – 60,000	222	32.5
60,000 – 90,000	104	15.2
> 90,000	101	14.7
Education		
High school or less	265	33.2
College	223	27.9
University degree	249	31.2
Other	62	7.8

Table 2
CAM Use among Participants with Diabetes

N=806	N	%
Any CAM use	749	92.9
Non-pharmacological CAM	647	80.3
Chiropractic	116	14.4
Healer	12	1.5
Acupuncture	46	5.7
Prayer/Meditation	289	35.9
Aromatherapy	28	3.5
Yoga	40	5.0
Massage	144	17.9
Relaxation	108	13.4
Hypnosis	4	0.0
Physiotherapy	7	0.9
Homeopathy	23	2.9
Exercise	538	66.8
Medicine Man / Woman	33	4.1
Different diet	226	28.0
Pharmacological CAM	660	81.9
Multivitamins	365	45.3
Herbal Remedies/Supplements	155	19.2
American Ginseng	22	2.7
St. John's Wart	14	1.7
Prickly Pear Cactus (nopal)	36	4.5
Green Tea	249	30.9
L-Carnitine	20	2.5
Chromium	79	9.8
Aloe Vera	52	6.5
Multivitamins	393	48.8
Glucosamine	134	16.6
Melatonin	19	2.4
Vitamin E	288	35.7
Chondroitin Sulfate	63	7.8
Echinacea	64	7.9
Ginko Biloba	50	6.2
Garlic	118	14.6
Noni Juice	22	2.7

Table 3
Pharmacological CAM Use in Participants with Diabetes by Ethnicity

CAM Type	N (%)						P value
	Caucasian 446 (56.0)	African-American 44 (5.5)	Hispanic/Latino 90 (11.3)	Native American 63 (7.9)	Asian 98 (12.3)	Pacific Islander/Other 56 (7.0)	
Any CAM *	420 (94.2)	42 (95.5)	86 (95.6)	60 (95.2)	86 (88.0)	47 (83.9)	0.02
Pharmacological CAM *	376 (84.3)	37 (84.1)	77 (85.6)	49 (77.8)	78 (79.6)	37 (66.1)	0.02
Aloe Vera	26 (5.8)	2 (4.6)	9 (10.0)	9 (14.3)	4 (4.1)	2 (3.6)	0.10
American Ginseng *	7 (1.6)	3 (6.8)	2 (2.2)	5 (7.9)	3 (3.1)	2 (3.6)	0.03
Chondroitin Sulfate	43 (9.6)	2 (4.6)	2 (2.2)	4 (6.4)	10 (10.2)	2 (3.6)	0.11
Chromium	47 (10.5)	6 (13.6)	9 (10.0)	8 (12.7)	4 (4.1)	5 (8.9)	0.31
Echinacea	34 (7.6)	2 (4.6)	5 (5.6)	7 (11.1)	12 (12.2)	4 (7.14)	0.47
Garcinia	2 (0.5)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.8)	0.53
Garlic	63 (14.1)	8 (18.2)	10 (11.1)	13 (20.6)	5 (13.3)	10 (17.9)	0.57
Ginkgo Biloba *	19 (4.3)	2 (4.6)	5 (5.6)	7 (11.1)	11 (11.2)	6 (10.7)	0.03
Glucosamine *	83 (18.6)	7 (15.9)	4 (4.4)	14 (22.2)	16 (16.3)	10 (17.9)	0.03
Green Tea	135 (30.3)	16 (36.4)	24 (26.7)	23 (36.5)	33 (33.7)	16 (28.6)	0.72
Herbal R/Supplements	94 (21.1)	7 (15.9)	13 (14.4)	10 (15.9)	21 (21.4)	10 (17.9)	0.64
L-Carnitine	11 (2.5)	3 (6.8)	0 (0.0)	4 (6.4)	1 (1.0)	1 (1.8)	0.05
Melatonin	11 (2.5)	1 (2.3)	1 (1.1)	2 (3.2)	4 (4.1)	0 (0.0)	0.66
Multi-vitamins ^{& †}	258 (57.9)	23 (52.3)	31 (34.4)	22 (34.9)	42 (42.9)	16 (28.6)	< 0.001
Noni Juice *	10 (2.2)	2 (4.6)	4 (4.4)	1 (1.6)	0 (0.0)	5 (8.9)	0.02
Prickly Pear Cactus [†]	1 (0.2)	0 (0.0)	30 (33.3)	2 (3.2)	1 (1.0)	0 (0.0)	< 0.001
St. John's Wart	9 (2.0)	1 (2.3)	0 (0.0)	2 (3.2)	1 (1.0)	1 (1.8)	0.62
Trumpet Flower	1 (0.2)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1.00
Vitamin E [†]	183 (41.0)	19 (43.2)	24 (26.7)	24 (38.1)	24 (24.5)	12 (21.4)	0.001

*
p < 0.05;

†
p ≤ 0.01;

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Table 4
Non-pharmacological CAM Use in Participants with Diabetes by Ethnicity

CAM	N (%)						P value
	Caucasians 446 (56.0)	African Americans 44 (5.5)	Hispanics 90 (11.3)	Native Americans 63 (7.9)	Asians 98 (12.3)	Pacific Islanders/Other 56 (7.0)	
Non-pharmacological CAM:*	373 (83.6)	37 (84.1)	73 (81.1)	45 (71.4)	69 (70.4)	42 (75.0)	0.02
Acupuncture	31 (7.0)	2 (4.6)	1 (1.1)	4 (6.4)	6 (6.1)	2 (3.6)	0.33
Aromatherapy*	15 (3.4)	3 (6.8)	3 (3.3)	6 (9.5)	1 (1.0)	0 (0.0)	0.04
Chiropractic*	81 (18.2)	3 (6.8)	9 (10.0)	7 (11.1)	12 (12.2)	4 (7.1)	0.04
Exercise	301 (67.5)	33 (75.0)	64 (71.1)	37 (58.7)	60 (61.2)	36 (64.3)	0.35
Healer	4 (0.9)	0 (0.0)	1 (1.1)	4 (6.4)	2 (2.0)	0 (0.0)	0.06
Herbopathy	12 (2.7)	1 (2.3)	5 (5.6)	2 (3.2)	3 (3.1)	0 (0.0)	0.53
Hypnosis	3 (0.7)	1 (2.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0.58
Massage	92 (20.6)	5 (11.4)	12 (13.3)	8 (12.7)	18 (18.4)	9 (16.1)	0.30
Medicine Man / Woman [†]	12 (2.7)	3 (6.8)	8 (8.9)	6 (9.5)	2 (2.0)	2 (3.6)	0.01
Physiotherapy	6 (1.4)	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.0)	0 (0.0)	0.97
Prayer/Meditation [^]	184 (41.3)	19 (43.2)	20 (22.2)	23 (36.5)	23 (23.5)	19 (33.9)	0.001
Relaxation	65 (14.6)	9 (20.5)	7 (7.8)	11 (17.3)	6 (6.1)	8 (14.3)	0.07
Special diet	125 (28.0)	12 (27.3)	32 (35.6)	19 (30.2)	22 (22.5)	14 (25.0)	0.49
Yoga	25 (5.6)	4 (9.1)	6 (6.7)	3 (4.7)	2 (2.0)	0 (0.0)	0.16

* p < 0.05;

[†] p ≤ 0.01;[^] p ≤ 0.001