

10 JAN 2003



**COMPLEMENTARY AND ALTERNATIVE THERAPY USING  
IN HOSPITALIZED HIV/AIDS PATIENTS**

**SAIJAI PINTOBTANG**

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With compliments  
of

บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF MASTER OF  
NURSING SCIENCE (ADULT NURSING)  
FACULTY OF GRADUATE STUDIES  
MAHIDOL UNIVERSITY  
2002**

ISBN 974-04-2501-1

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2002  
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**COMPLEMENTARY AND ALTERNATIVE THERAPY USING  
IN HOSPITALIZED HIV/AIDS PATIENT**

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was submitted to the Faculty of Graduate Studies, Mahidol University  
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## ACKNOWLEDGEMENT

I would like to express my deepest gratitude and sincere appreciation to Assistant Professor Dr. Ladaval Ounprasertpong, my principal thesis advisor for her patience, suggestion, attention, encouragement, support, and invaluable guidance throughout this study. My appreciation and gratitude is also extended to Professor Somchit Hanucharurnkul, my co-advisor, for her understanding, encouragement, support, invaluable guidance, and kindness. I am also grateful for Assistant Professor Dr. Khannika Suwonnakote and Dr. Jakkriess Bhumisawasdi for their valuable comments and supervision.

My sincere thanks go to Associate Professor Dr. Yuwadee Luecha, chairman of Master of Nursing Science Program, for her patience, understanding, and encouragement throughout this study.

I am very grateful to the Nursing Department, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, for providing me with time and opportunity to undertake this study program.

I am particularly indebted to the Head of the Nursing Department and the staff nurses of Medicine Out - Patients Department for providing me with the opportunity, which enabled me to undertake this study.

My gratitude also goes to Dr. Attaporn Hirunyapruerk for her assistance in seeking the data at the Ministry of Public Health for this study.

Special thanks go to my friends, my older and younger sisters at Faculty of Nursing, Ramathibodi Hospital, and friends in the Master Degree program No.21 at Ramathibodi School of Nursing for their love, encouragement, and support throughout the study program.

My deepest appreciation is to Miss Tipporn Sae-choen for her guidance, encouragement, and emotional support, especially when I found myself difficult and trying situation. Because of her, I could overcome all the hardship I found along the path.

Deep thanks go to my parents, my sister, my sister in law, and Supich Boonprakorb (my niece) for their love, support, and assistance. Special thanks are extended to my family: Dr. Prapart Pintobtang, my husband, as well as Ployjai and Boonnada Pintobtang, my two lovely daughters, for their love, assistance, understanding, and emotional support throughout the study.

Finally, my deepest appreciation is expressed to HIV/AIDS patients, who were attempting to achieve a sense of well being during their illness trajectory for their willingness to participate in this study. I am thankful for the time and experiences they kindly shared with me. Without their cooperation, the completion of this study would not have been possible.

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**KEY WORDS : COMPLEMENTARY/ALTERNATIVE THERAPY USING  
HIV/AIDS PATIENTS/HOSPITALIZED PATIENTS**

**SAIJAI PINTOBTANG: COMPLEMENTARY AND ALTERNATIVE  
THERAPY USING IN HOSPITALIZED HIV/AIDS PATIENTS. THESIS ADVISORS:  
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97 P. ISBN 974-04-2501-1**

The purpose of this study was to explore complementary and alternative therapy (CAT), reasons for their use, the original sources leading HIV/AIDS patients to use CAT, sources of information about CAT, the indicators which were used to evaluate the efficacy of CAT, perceived efficacy, and the expenditure for CAT. Kleinman's explanatory model was used as a conceptual framework for this study. The purposive sample of 115 HIV/AIDS patients who came to a follow up at the Out-Patient Department of Medicine at Ramathibodi Hospital from June to August 2002 was selected as the subjects for this study. The inclusion criteria were as follows: a) 15 years of age or over, b) diagnosed by the physicians to be infected with HIV and having been informed about the diagnostic result for at least 8 weeks, at whatever stage of disease, c) good consciousness and Thai language speaking ability, d) willing to participate in this study, and e) going on foot to the Out-Patient Department of Medicine or being transferred by a wheelchair. Data were collected by interviewing, using a semi-structured open-ended interview form and other relevant data from medical records.

The results of the study revealed that 99 subjects (86.1%) used CAT combined with conventional medicine. The most important group of CAT used was body-mind control, followed by diet/nutrition/lifestyle change, herbs, manual healing, and energy therapy. The three main reasons which were used to perform CAT were symptom distresses, followed by suggestions from others, and promoting health. As for symptom distress, the sample initiated CAT by themselves (54.05%) and performed CAT because of the influence of suggestions from others (45.95%). For promoting health, the sample initiated CAT by themselves (35.4%) and performed CAT because of the influence of suggestions from others (64.6%). The popular sources of information about CAT were family or relatives (27.2%), followed by media (23.4%), friends (17.9%), health personnel (13.6%), neighbors (7.4%), drugstores (6.8%), and the AIDS social network (3.1%). The indicator used in evaluating the efficacy of CAT was symptom relief. Regarding perceived efficacy of CAT, when dividing the data into a variety of modalities, the number of use of each sort of CAT was too small to explain the efficacy of CAT. However, the level of the perceived efficacy tended to show that CAT could respond to patients' needs in the aspect of symptom distresses. The mean of monthly expenditure for each sort of CAT was between 22.50-1067.98 baht. The most expensive sort of CAT was herbs, followed by nutritional supplements and massage.

Although viruses, a cause of illness in HIV/AIDS patients, cannot be eliminated from of the body, the important goal of nursing care is to manage symptom distresses. Whatever form of symptom management, either conventional medicine or alternative medicine, they can be integrated for fulfillment of holistic care. This study shows that close to half of HIV/AIDS patients (42.58%) who came to receive treatment with conventional medicine also used alternative medicine to relieve symptom distresses. The findings help nurses to better understand healthcare behavior of HIV/AIDS patients and guide the appropriate care for symptom distresses created by an illness. Moreover, the findings could be a guide to develop research congruent with the patients' needs.

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สายใจ ปิ่นตบแต่ง : การใช้การรักษาแบบผสมผสานและการแพทย์ทางเลือกในผู้ติดเชื้อเอช ไอ วีและผู้ป่วยเอดส์ที่มา  
รับการรักษาในโรงพยาบาล (COMPLEMENTARY AND ALTERNATIVE THERAPY USING IN HOSPITALIZED HIV/AIDS  
PATIENTS). คณะกรรมการควบคุมวิทยานิพนธ์ : ลดาวัลย์ อุ่นประเสริฐพงศ์ พย.ค, สมจิต หนูเจริญกุล, Ph.D. (Nursing),  
97 หน้า ISBN 974-04-2501-1

การศึกษาเชิงพรรณานี้มีวัตถุประสงค์เพื่อ สํารวจการใช้การรักษาแบบผสมผสานและการแพทย์ทางเลือกในผู้ติดเชื้อ  
เอช ไอวีและผู้ป่วยเอดส์ เหตุผลที่ผู้ป่วยตัดสินใจใช้ แหล่งที่มาของการตัดสินใจใช้ รวมทั้งแหล่งข้อมูล ข่าวสารที่ผู้ป่วยใช้  
ประกอบการตัดสินใจ ตัวบ่งชี้ประสิทธิภาพของวิธีการรักษา ประสิทธิภาพของการใช้การรักษาแบบผสมผสานและการแพทย์  
ทางเลือกตามการรับรู้ของผู้ป่วย ตลอดจนค่าใช้จ่ายในการใช้การรักษาแบบผสมผสานและการแพทย์ทางเลือก โดยใช้กรอบแนวคิด  
การอธิบายเกี่ยวกับความเจ็บป่วยของโคลแมนเป็นกรอบแนวคิดในการศึกษา กลุ่มตัวอย่าง คือ ผู้ติดเชื้อเอชไอวีและผู้ป่วยเอดส์ที่มา  
รับการรักษาที่หน่วยตรวจผู้ป่วยนอกอายุรกรรม โรงพยาบาลรามารินทร์ ระหว่างเดือนมิถุนายนถึงสิงหาคม พ.ศ. 2545 จำนวน  
115 ราย โดยเลือกกลุ่มตัวอย่างแบบเฉพาะเจาะจงตามคุณสมบัติที่กำหนด เก็บข้อมูลโดยใช้แบบสัมภาษณ์ ซึ่งประกอบด้วย แบบ  
บันทึกข้อมูลพื้นฐานส่วนบุคคล ประวัติการเจ็บป่วยและการรักษา และแบบสัมภาษณ์แบบกึ่ง โครงสร้างในส่วนของคำถามเกี่ยวกับ  
เหตุผล แหล่งที่มาของการตัดสินใจใช้วิธีการรักษาแบบผสมผสานและการแพทย์ทางเลือก แหล่งข้อมูลข่าวสาร ตัวชี้วัด  
ประสิทธิภาพ การรับรู้ประสิทธิภาพและค่าใช้จ่ายในการใช้การรักษาแบบผสมผสานและการแพทย์ทางเลือก ข้อมูลที่ได้นำมา  
วิเคราะห์โดยใช้สถิติเชิงบรรยาย

ผลการศึกษาพบว่า กลุ่มตัวอย่างใช้การรักษาแบบผสมผสานและการแพทย์ทางเลือกร่วมกับการรักษาแผนปัจจุบัน ร้อย  
ละ 86.1 กลุ่มของศาสตร์การแพทย์ทางเลือกที่ใช้มากที่สุดได้แก่ การใช้หลักการจิตสัมพันธ์กับกาย การปรับเปลี่ยนพฤติกรรม  
บริโภคอาหารหรือการเสริมคุณค่าอาหารและโภชนาการ การใช้สมุนไพร การรักษาด้วยศาสตร์ที่ใช้การสัมผัสหรือใช้มือในการ  
วินิจฉัยหรือบำบัดอาการ และกลุ่มศาสตร์ที่ว่าด้วยความสัมพันธ์ระหว่างสิ่งมีชีวิตกับสนามแม่เหล็กไฟฟ้า/พลังสนามแม่เหล็กไฟฟ้า  
ในตมมนุษย์ ตามลำดับ เหตุผลที่ใช้ในการตัดสินใจใช้การรักษาแบบผสมผสานและการแพทย์ทางเลือกที่พบบ่อยได้แก่ ความ  
ต้องการลดอาการทุกข์ทรมาน อิทธิพลจากการได้รับคำแนะนำจากแหล่งข้อมูลต่างๆ และความต้องการเสริมสร้างภาวะสุขภาพ กลุ่ม  
ตัวอย่างซึ่งได้รับความทุกข์ทรมานจากอาการร้อยละ 54.05 ริเริ่มการรักษาแบบผสมผสานด้วยตนเอง กลุ่มที่ใช้การรักษาแบบ  
ผสมผสานเพราะต้องการเสริมสร้างภาวะสุขภาพร้อยละ 64.6 ใช้การรักษาแบบผสมผสานเพราะอิทธิพลของข้อมูล ข่าวสารจาก  
แหล่งต่างๆ แหล่งข้อมูลข่าวสารที่มีอิทธิพลต่อการตัดสินใจมากที่สุดตามลำดับได้แก่ คำแนะนำจากครอบครัวหรือเครือญาติร้อยละ  
27.2 สื่อต่างๆร้อยละ 23.4 เพื่อนร้อยละ 17.9 บุคลากรในทีมสุขภาพร้อยละ 13.6 เพื่อนบ้านร้อยละ 7.4 ร้านขายยาร้อยละ 6.8  
เครือข่ายทางสังคมของกลุ่มผู้ติดเชื้อเอชไอวีร้อยละ 3.1 ตัวชี้วัดประสิทธิภาพของการใช้การรักษาแบบผสมผสานและการแพทย์  
ทางเลือกคือ ประสิทธิภาพในการลดความทุกข์ทรมานจากอาการ ในส่วนของการรับรู้ประสิทธิภาพพบว่าเมื่อจำแนกประสิทธิภาพ  
ตามชนิดของการรักษาแบบผสมผสานทำให้ขนาดของกลุ่มตัวอย่างเล็กมากจนไม่สามารถนำมาอธิบายการรับรู้ประสิทธิภาพได้ แต่  
อย่างไรก็ตามแนวโน้มระดับคะแนนของการรับรู้ประสิทธิภาพของการใช้การรักษาแบบผสมผสานแสดงให้เห็นว่า การใช้รักษา  
แบบผสมผสานและการแพทย์ทางเลือกสามารถตอบสนองความต้องการของผู้ป่วยในด้านการลดความทุกข์ทรมานได้ ค่าใช้จ่าย  
เฉลี่ยต่อเดือนของการใช้การรักษาแบบผสมผสานแต่ละชนิดอยู่ในระหว่าง 22.50 – 1067.98 บาท โดยพบว่ากลุ่มของศาสตร์  
การแพทย์ทางเลือกที่มีค่าใช้จ่ายสูงได้แก่ การใช้สมุนไพร การใช้ผลิตภัณฑ์อาหารเสริม และการนวดตามลำดับ เป้าหมายสำคัญ  
ของการพยาบาลผู้ป่วยเอดส์คือการขจัดหรือลดอาการไม่สุขสบาย แม้ว่าจะไม่สามารถขจัดสาเหตุของการเกิดโรคคือเชื้อไวรัสใน  
ร่างกายของผู้ป่วยได้ การจัดการกับอาการที่จะช่วยลดอาการทุกข์ทรมานไม่ว่าจะด้วยวิธีการแพทย์แผนปัจจุบันหรือแพทย์ทางเลือก  
สามารถนำมาผสมผสานในการดูแลผู้ป่วยให้ครบองค์รวม งานวิจัยนี้ชี้ให้เห็นว่าผู้ป่วยที่มารับการรักษาที่แผนปัจจุบันส่วน  
ใหญ่ผสมผสานการแพทย์ทางเลือกในการบรรเทาอาการทุกข์ทรมานถึงร้อยละ 42.58 ช่วยให้พยาบาลเข้าใจพฤติกรรมดูแลสุขภาพ  
ของผู้ติดเชื้อเอชไอวี/เอดส์ ซึ่งเป็นแนวทางในการปฏิบัติพยาบาลในเรื่องการจัดการกับอาการที่เกิดขึ้น ตลอดจนการศึกษาวิจัย  
เพื่อให้สอดคล้องกับความต้องการของผู้ป่วยต่อไป

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## CHAPTER I

### INTRODUCTION

#### **Background and Rationale**

Being infected with HIV virus is a catastrophic event (Nichol, 1985: 765). AIDS is different from other life threatening diseases because of the progression of the disease which has a rapid downhill course, with no definite treatment, and because a patient is stigmatized by society (Derdiarian & Schobel, 1990; cited in Gaskin & Brown, 1992: 112). Physical impacts due to disease progression result in the impairment of functional ability and severe symptom distresses. Psychological impacts such as stigmatization, life style changes, illness-related uncertainty, and existential issue related to diagnosis with a life threatening chronic illness are the important factors which affect are the capability of patients to cope with the illness. Because of the severe impacts which are created by an illness, these situations force patients to use high energy to cope with the illness. These struggles not only emerge in the advanced stage of the disease, but also occur at the beginning of an illness trajectory, which may at time overwhelm the individual's coping resources (MacCain & Cella, 1995: 141).

According to UNAIDS and WHO, 40 million persons were estimated to be living with HIV/AIDS in the world at the end of 2001. During the year 2001, 5 million persons were newly infected with HIV. In South East Asia, 5 million persons were estimated to be living with HIV/AIDS. The number of AIDS cases reported in Thailand from 1984 to 30 April 2002 totaled 266,554, of which 61,204 persons have

died. At the moment, AIDS cases are reported about 1,000 persons for each month (Division of epidemiology, Office of the Permanent Secretary, Ministry of Public Health, 2002: 59).

Although medical technology stated that HIV/AIDS patients can be treated because there are many anti-HIV drugs and new technology to detect and treat opportunistic infections, but the disease itself cannot be cured. With a limitation of anti-HIV drugs, which cannot get rid of all the HIV viruses in the body, but the viruses still live in a cell of the brain and lymph nodes, disease cannot be cured. The other reason is drug resistance, whose causes always be explained in two ways. The first is the compliance of a patient to administrate drugs. The second is the side effects of anti-HIV drugs which patients cannot tolerate such as nausea, vomiting, headache, and myalgia. Especially in long-term care, the side effect of drugs can develop hyperglycemia, hyperlipidemia, and lipodystrophy (Panupak, 2001: 2).

Other serious problems concern economic status of the patients, society and the country. HIV/AIDS patients in a rich country have accesses to healthcare systems and receive anti-HIV drugs to prolong life, but 90% of patients in a developing country have no chance to take anti-HIV drugs (Narain, 2000: 2).

For Thailand, each HIV/AIDS patient needs money to treat opportunistic infections or for the secondary prophylaxis, which costs about 3,000 baht per year. At an advanced stage, the expenditures that are paid are even more expensive because of the characteristics of the opportunistic infections and the decreasing immunity. The serious economic problems of the healthcare system and the HIV/AIDS patients are created by some kinds of opportunistic infections such as cryptococcosis, pennicillosis, and histoplasmosis. These cases need drugs to control an infection

through their life spans. It has been estimated that the expenditure for maintenance therapy is about 120-250 baht per day. Although now our country has the ability to produce these drugs at a low price, at last drug resistance results in high expenditure again. On the overall, each AIDS case needs the expenditure for drugs about 44,000 baht per year (Kunanuson, 2000: 45).

According to the limitation as mentioned above, although the conventional medical systems can help HIV/AIDS patients to prolong life but disease cannot be cured. Meanwhile, new problems are created such as high cost, failure of the health care system to fulfill psychosocial needs of patients and family, and dehumanization (Chuengsatiensub, 1999: 12). Illness impact including health deviation, side effects of treatment, and economic problems along with healthcare systems in our country can not respond to patients' need sufficiency resulting in more complicate health care needs in AIDS cases with the above limitations. These factors lead the patients to struggle and look for a new alternative way to solve health problems, a common pattern of behavior found in crisis situation of human.

The Cheewajit Phenomena, a new concept about healthcare behavior, reflects that health concepts of Thai society are in a crisis situation, leading persons to struggle and seek a new way to manage the health problems. This crisis cannot be solved by new medical knowledge, but it signifies a review of the definition of health in a new dimension that reflects holistic concept to solve this crisis (Chuengsatiensub, 1999: 45). The other phenomenon is the movement of HIV/AIDS patients in the north of Thailand to help each other to manage health problems by using Thai herbal medicines. In 1992, priests and folk medical healers played the important role to solve

health problems, leading to the turning point of Thai public health. Finally, the Ministry of Public Health has changed a perspective about AIDS from incurable disease to the dimension of medical anthropology which points out that the AIDS problem has a way to decrease the suffering of patients.

Focusing on “person” is a key concept of the measures of The National Committee of Prevention and Solving AIDS Problem (2002-2007). The strategies are to develop health service, promotion and support the research about complementary and alternative therapies. These measures along with a policy about promoting complementary and alternative therapies in every level of healthcare system result in an easy access to care and a new way to promote health within the Thai socio-cultural context.

A focus of nursing is also a person. Nurses care for persons as a whole based on a philosophy of holistic care, including physical, psychosocial, and spiritual dimensions. In Kleinman’s Explanatory Model, he explains health seeking behavior when the persons get sick. They try to take care of themselves by using popular, folk, and professional sectors. This model shows us that the patients do not go to see the doctor at the hospital alone. Instead, they also try to take care of themselves by intergrating alternative medicine. This point of view made the researcher interested in the aspects of the reasons HIV/AIDS patients decide to use them, the indicator that the patients use to evaluate the efficacy, perceived efficacy of complementary and alternative therapies, and other contexts such as sources of information about complementary and alternative therapies and expenditure paid in each sort of complementary and alternative therapies. To better understand the use of complementary and alternative therapies, data concerning the behavior of Thai

hospitalized HIV/AIDS patients could be a guide to develop the nursing practice to promote well-being and quality of life of HIV/AIDS patients.

### **Conceptual Framework**

The research framework in this study was derived from the explanatory model of illness. The model was first developed by Arther Kleinman, a psychiatrist who studied anthropology. His study found that what people perceived and use to manage the illness is based on the patients' explanation of illness (Kleinman, 1978; cited in Hanucharoenkul, 2537: 8)

According to the model, healthcare system is defined as cultural system like the language or religion. Patients and healers are the basic components. The model of the healthcare system is also derived from studying the way people act in it and use its components. It is both the result and the condition in which people respond to sickness in the socio-cultural context in that society such as how they perceive, label, explain, and treat sickness. Healthcare system including people's beliefs and patterns of behavior both of which are determined by culture. In the healing process, there is an explanation to gain meaning about sickness in the patient's social context and social relationship system ( Kleinman, 1980: 26 ).

Illness is not only a personal experience but also is the response to sickness of that society which develops through long-term socialization and cultural specific as well. The way a person explains an illness is a psychosocial experience. Illness is culturally shaped in the sense that how individuals perceive, experience, and cope with the disease is based on the explanation of illness, explanation specific to the

social position they occupy and system of meaning which they employ. These explanations are different from those in the western medical paradigm. “Disease” in western medical paradigm is malfunctioning or maladaptation of biologic and psychophysiologic processes in the individual, whereas “illness” represents personal, interpersonal, and cultural reaction to disease or discomfort (Kleinman, 1978: 252).

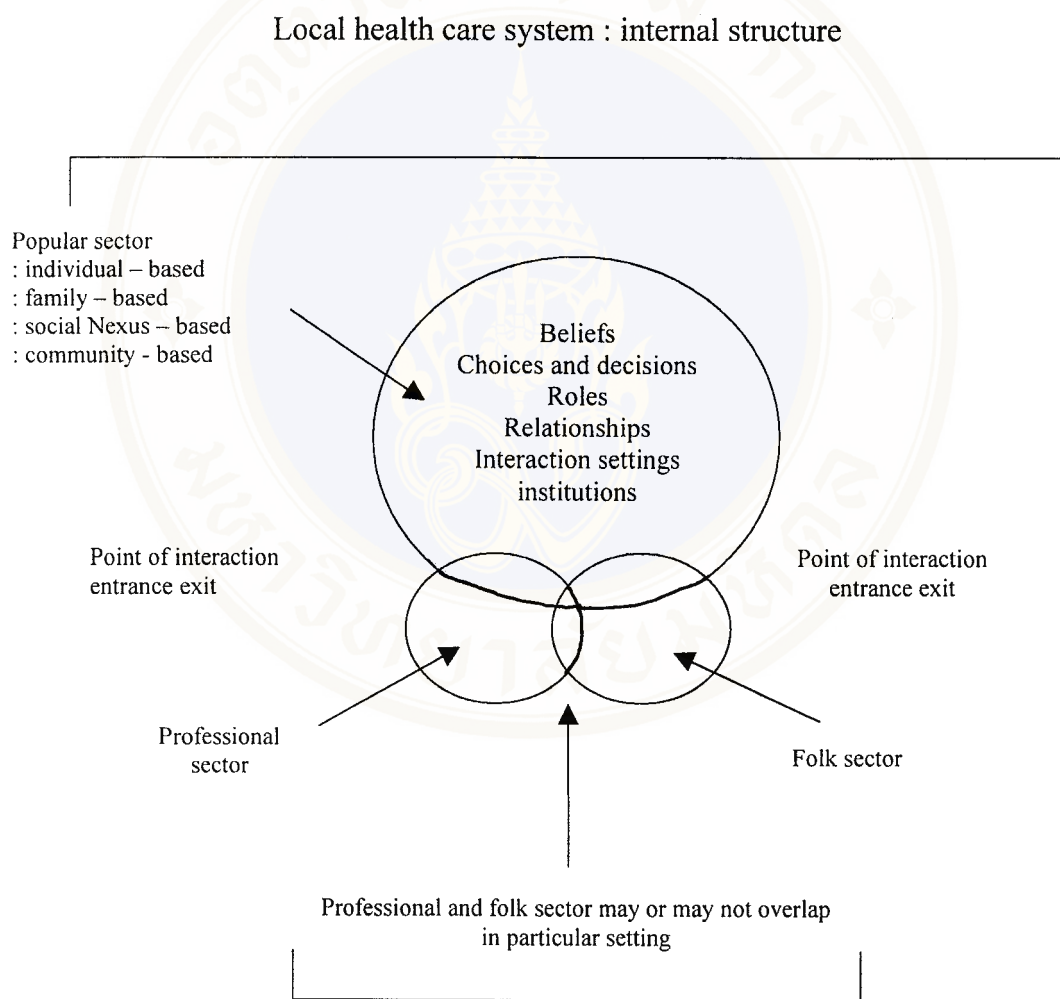


figure 1 Kleinman’s model of internal structure in local health care system

( Kleinman, 1980 : 50 )

Healthcare system, as well as cultural system, consists of three structure domains of healthcare in society as follows: the professional healthcare sector, the popular health care sector, and the folk healthcare sector (Kleinman, 1980: 50).

1. The professional healthcare sector is the organized, regulated, legally sanctioned health profession, such as western medicine. Some societies may have professional medical system in addition to western one, such as Chinese or Oriental medicine in China and Ayurveda in India.

2. The popular healthcare sector is the largest part of any healthcare system and consists of the lay, non-professional, non-specialist arena in which illness is initially defined for an individual and treatment is initiated. The popular healthcare sector can be conceptualized to contain many levels, including individual, family, social network, and community. An individual may use one or more of these levels for assistance during an illness episode to define symptoms, decide where to seek treatment, engage in treatment, and evaluate treatment outcomes. Self-treatment is generally the first resort when an individual becomes ill, and self-treatment practices are grounded in popular healthcare beliefs and practices. After treatment is received, regardless of whether given by the popular, professional or folk sectors, patients rely on the popular sector to evaluate treatment, and if necessary, decide upon the next course of action.

3. The folk healthcare sector is the non-professional, non-bureaucratic, specialist sector that may overlap with the professional and popular sectors. Folk medicine practitioners include the herbalist, local orthopedic doctor, doctor who helps in averting a catastrophe by a magic means, fortuneteller, holy water springle, etc. In

some societies where professional medicine is absent, the folk healthcare sector and popular healthcare sectors are the main healthcare resources. Also, folk health beliefs and practices may be secular or sacred, or a combination of both.

Patients' beliefs and patterns of health behavior are determined by the cultural rule. To understand this model, it is important to understand how patients in a particular social setting think about healthcare, their beliefs about sickness, their decision about how to respond to specific episode of sickness, and their expectation and evaluation of a particular kind of care (Kleinman, 1980: 26). This model is consistent with seeking healthcare services in HIV/AIDS patients in the healthcare system of Thai society, which has particular characteristics, called 'pluralism,' helpful in understanding complementary and alternative therapies use behavior in HIV/AIDS patients.

### **Research objectives**

1. To explore complementary and alternative therapy use in HIV/AIDS patients.
2. To describe the reasons which HIV/AIDS patients choose to explain in decision-making about complementary and alternative therapy use.
3. To explore the original sources that lead HIV/AIDS patients to choose each sort of complementary and alternative therapies and sources of information about complementary and alternative therapies.
4. To explore the indicators which the HIV/AIDS patients use to evaluate the efficacy of complementary and alternative therapies and their perceived the efficacy of complementary and alternative therapy after they have used them.

5. To explore the expenditure which HIV/AIDS patients pay for each sort of complementary and alternative therapies.

### **Research questions**

1. What sort of complementary and alternative therapy do HIV/AIDS patients use?
2. What is HIV/AIDS patients' reason for using complementary and alternative therapy?
3. What is the original source that leads HIV/AIDS patients to use each sort of complementary and alternative therapies and what is the source of information about complementary and alternative therapies which HIV/AIDS patients use?
4. What is the indicator for HIV/AIDS patients' perceived efficacy of complementary and alternative therapy, and what is the level of the efficacy they perceive?
5. How much is the monthly expenditure which HIV/AIDS patients pay for each sort of complementary and alternative therapies?

### **Scope of the Study**

This research is a descriptive research study aiming to explore sorts of complementary and alternative therapy use, reasons for using them, the original sources that lead the patients to choose each sort of complementary and alternative therapies, the indicators to evaluate the efficacy, patients' perceived efficacy, and the expenditure of complementary and alternative therapies use in HIV/AIDS patients

who came to the follow-up at the Out-Patient Department of Medicine at Ramathibodi Hospital.

### **Significance of the study**

1. To be basic data beneficial in understanding complementary and alternative therapies using behavior of HIV/AIDS patients
2. To use as a guideline in providing appropriate care consistent with the needs of HIV/AIDS patients
3. To be a guide for further research on complementary and alternative therapy using behavior in HIV/AIDS patients

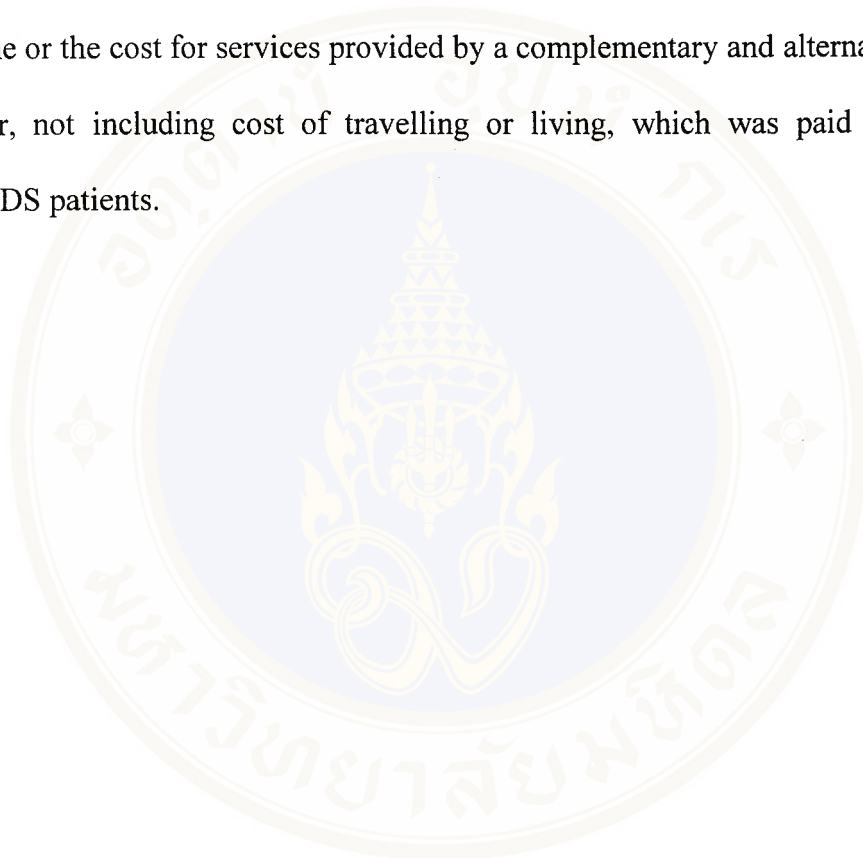
### **Definition of Terms**

**“Complementary and alternative therapies”** in this study are defined as any sort of practice except for conventional medicine. The categories included are; mind-body control, diet/nutrition/life-style changes, herbs, manual healing, and energy therapy. These categories are applied from the definition provided by National Center for Complementary and Alternative Medicine (NCCAM) of the United States (1992) which is consistent with the Thai socio-cultural context of HIV/AIDS patients.

**“The level of perceived efficacy”** refers to the score that was rated by the patients for each sort of complementary and alternative therapies which relieved the severity of symptoms such as anxiety, pain, etc. Possible scores ranged from 0 to 10. Ten points meant that that particular sort of complementary and alternative therapy was the most helpful practice for patients to decrease their symptom severity, while

zero point meant that sort of complementary and alternative therapy had no usefulness for them to relieve the severity of their symptom.

“**The expenditure**” in this study meant the cost in whatever form of medicine or the cost for services provided by a complementary and alternative therapy provider, not including cost of travelling or living, which was paid monthly by HIV/AIDS patients.



## **CHAPTER II**

### **LITERATURE REVIEW**

This research was a descriptive research study which attempted to study major issues concerning the complementary and alternative therapy for HIV/AIDS patients: sorts of complementary and alternative therapy, the reasons for those patients' use of complementary and alternative therapy, the efficacy of the complementary and alternative therapy according to the perception of the patients, the sources of information about the complementary and alternative therapy; and the expenditure of each therapy. In this study, related literature was reviewed in the following topics:

1. Medical pluralism
2. The concept of illness in Thai culture
3. Complementary and alternative therapy
4. Related factors influencing to use complementary and alternative therapy
5. Complementary and alternative therapy use in HIV/AIDS patients

#### **Medical Pluralism**

The "Medical Anthropology" is the science which studies the culture of medical system and its coping with illness within different cultures and societies. It concludes that every society has more than one healthcare system. Moreover, regarding the concept of "Medical Pluralism," there is more than one healthcare system existing and playing role in the society. Each of them comprises different



ways of thinking, theories, and cultures. This phenomenon reflects the reality that there is no one completed healthcare system which can treat every disease and satisfy every dimension of the patient's demands (Chungsatiensap, 1990: 602). The health care system is composed of two fundamental concepts:

1. Disease theory system: it explains the phenomenon of illness, including factors causing the illness and the process of treatment. This concept plays important role in framing the reaction, behavior, pattern, and healthcare system, in responding to the illness.

2. Healthcare system: it is the system constructing by the society in order to promote, maintain, and solve health problems. The system includes health personnel, patients, places where the healthcare activities take place, pattern of medical treatment process, medicines, equipment, and the relationships between the doctors and patients. There are several concepts in this system which the society uses in systematizing the healthcare treatment and system, for instance, who could play the role in providing healthcare services and the relationships between the doctors and patients. These concepts are reflected through the way of thought about disease theory system, as well as the attitudes and decision making-process in dealing with illness. Healthcare system in every society is pluralistic in its character, by having a conventional medicine as a major system, and others as alternative choices (Nanthabuth, 1999: 29).

Thus, the healthcare behavior under the system of "Medical Pluralism" has diverse and supportive directions some of which are different from those in the conventional medicine. Nanthabuth (1999) states that, "the society in the concept of medical pluralistic system comprises many different medical treatment cultures. They

co-exist and support each other in order to maintain the balance of health for people in community. Owing to the different ways of thinking about reasons of illness and the medical treatments, the patients and concerning groups have more choices in handling with the health problem. Thus, the illness behavior and the treatment pattern are not limited in any one particular form. Many other forms of treatment which are accepted by the rural villagers, and considered as the best means, are also able to exist in the social system”.

The medical pluralistic system in Thai society can be considered as the integrated medical treatment between the concepts of conventional medicine and folk medicine or alternative therapies. The folk medicine includes both the Thai traditional medicines and folk medical doctor. As for the alternative therapy in Thai society, it comprises Yo-re, Meditation, Chinese herb and Chinese medicine, Moh-Mah treatment, Egg treatment, readjusting suffering and griefs, eliminating negative life impacts treatment, treating by using the burning glass, and coin polishing treatment for headache, for instance (Nanthabuth, 1999: 29).

Thus, this research attempted to study the complementary and alternative therapies for the HIV/AIDS patients within the medical pluralistic system which is different from the conventional medicine. In order to do so, it is necessary to understand the two fundamental concepts existing in Thai society including the concept of illness in Thai culture and the concept of complementary and alternative therapy .

### **The concept of illness in Thai culture**

Culture is the way of life and behavior. It is integrated and complex in terms of its character. It comprises knowledge, beliefs, arts, law, customs, individual ability, and manner which are transferred from one generation to another generation. Moreover, it includes language, symbolic system, perception, and other technologies (Hongvivat, 1985:240). Illness is one of the phenomena that every human being has to face. The culture of illness is the subsystem under the whole cultural system. Besides acting as the fundamental concept in defining the meaning of illness, the culture of illness also indicates the pattern of treatment handling with the illness.

Way of thinking in any culture changes all the time. It transfers or integrated any new concept into their system. The concept would decline if it cannot respond to problematic situation or to satisfy the demand of people within that society. The integration among different cultures makes the concept changed and adjusted continuously. The concept of healthcare system and illness in Thai society was originated among the mixture of different beliefs, including spiritualism, Hinduism and Buddhism. It has played a significant role in developing the healthcare behavior of Thai people. Even though nowadays the effectiveness of the conventional medicine is clearly approved and accepted, it is not the only one knowledge to indicate the healthcare behavior of local villagers. The way of thinking, perception, and healthcare behavior still has developed under the local concept and culture (Chungsatiensap, 1990: 599).

Chungsatiensap (cited in Diloktanakul, 1997: 12) categorized the Thai traditional healthcare system into four sub-systems, according to the way of thought and belief influencing the behavior in handling the illness:

1. Direct experienced medical system: Regarding this system, the skill and knowledge of medical treatment are accumulated from experiences, which are transferred from the previous generation. Occasionally, they have not been developed systematically. The process of treatment was originated in different local areas which have their own uniqueness. However, we can classify the pattern of treatment in three categories: 1) Treatment by applying the local medical product, for instance, herbal medicine from their own garden, 2) Treatment by following specific instruction such as local taboo, and 3) Treatment from local medical doctors including treatment with the local orthopedic specialist.

2. Superstitious and supernatural power medical treatment system: It is directly related to a spiritual belief. The belief of superstition considers that the illness is originated from the conflict between human behavior and regulations of social relations. Thus, the philosophy of the disease applies the concept of sickness as the means to regulate and control the social behavior and to solve the conflict problem within society. It can further be divided into three major groups (Chungsatiensap, 1990: 612):

2.1 The belief of spirit as the holy power which works to protect and preserve every life in nature. These spirits are generally named regarding to their location. For example, "Jaw-tee" (the supreme power within that location), "Jaw-pha" (the supreme power in the forest), "Ruk-ka Te-wa-da" (angle locating in the forest), "Mea Pho-sop" (mother of rice), "Mea Ya-nang" or "Phee-fah" (sky spirit).

2.2 The belief of the spirit of persons who passed away: The ghost of ancestor is the prominent example. Their name are usually relevant to their original area, for instance, the belief of the ghost of grandfather and grandmother in the northern, central, and southern Thailand, and the ghost of each family which takes care of the children within that family.

2.3 The belief of the devil spirit: In particular, some of those spirits attempt to cause suffering and grievances to human, such as “Phee-Phong” “Phee Khong-koi,” and “Phee Tai-hong” (spirit of person who were killed in an accident). These spirits are perceived as the factor causing the illness through various ways such as frightening and or they scaring people, so that they get fever, and haunt in one body until the owner of the body gets sick or becomes insane.

3. The astrology and adversity medical treatment system: The concept of this treatment applies the complicated mathematics and astrological methodology as the means to explain the phenomena and the relationships of substances within the universe based on the idea that every substance relates to and influences each other one way or the other. The changing of any element is according to their path and destiny controlled by “Chak Ra See”. Thus, astrology is the major methodology in understanding the existing condition and predicting the direction of the changes. It has a profound relationship with timing, space, and direction. These factors indicate the prosperity or misfortune. Illness is considered as a misfortune. But since the astrology can also be used as a means of fortune telling about the future, the idea of changing misfortune through ritual becomes significant. As we notice in the northeastern (Isaan) part of Thailand, there are several kinds of ceremonies which aim at eliminating the misfortune, such as “Tank Boo-cha Pra-kror” or “Tank Kea Boo-cha”.

4. The medical treatment system based on the “Tad” (substance) theory:

This treatment is based on the belief that every substance in nature is composed of four fundamental elements: earth, water, wind and fire. Being in good health is the result of a balance of these four elements in the human body. Moreover, at the people level, the idea of Tad also means the disease and sickness concerning stomach and food. For instance, “Tad Kam-reub” indicates symptoms of stomach discomfort, while “Tad nak – tad baw” explains the efficacy of the digestive functioning of each person. According to the idea of “Tad,” there are twelve factors leading to the sickness:

- 1) Food: eating too much or too little food, spoiled food, or unfamiliar food.
- 2) The improper standing, walking, sitting and sleeping manner
- 3) Hot weather
- 4) Cold weather
- 5) Not having enough sleep
- 6) Not having enough food
- 7) Not having drinking enough water
- 8) Not going to the toilet in the proper time to pass the urine
- 9) Not going to stool
- 10) Overload of working
- 11) Distressing
- 12) Anger

Furthermore, the analysis is also able to explain the origin of each disease:

- 1) disease caused by the changing irregularly of Tad; 2) disease caused by the irregular change of season and weather; 3) influence of date and timing of birth; and

4) influence of timing. For instance, local people consider the menopause period is the time that the direction of blood circulation changes. It is the physical transition period, from middle age to old age. During this transition period, people may be suffering from the illness caused by the Tad, for example, having a stroke and feeling dizzy. Thus, the treatment process emphasizes readjusting the balancing condition within the human body by using the herbal treatment. This treatment can be classified by its flavor: hot and spicy flavor to release the gas from the stomach, and sour flavor to release the secretion.

In the society, the health seeking behavior of people comprises more than one medical system. For instance, the concept of illness in the communities in the northern part of Thailand reflects their belief that the human body is the balance composition between concrete and abstract elements: physical part (Tad) and mental part (“Kwan” or spirit).

When there is any factor affecting the balance of both body and spirit, it will affect the health. For instance, when spirit falls, loses, disappears, or becomes weak or disabled. If anyone gets sick, the diagnosing process begins with asking for the personal history, including, age, occupation, family life, personal habit in the past, the illness in the past, physical checkup, fortune checking, and calculating the combination of Tad. Then it would come to the conclusion that the problem comes from the spirit, misfortune, ghost, or Tad. The result of the diagnosis is will be used in adjusting and balancing the body and spirit condition. The healing process can be done by readjusting the balance between human and nature such as by fulfilling the lacking side and reducing the surplus areas, eliminating the toxic element, treating the disease, and giving nourishment to the body. Sometimes, people also use the herbal

and ceremonial treatment, such as the ceremony of sending away the misfortune, the ceremony of inviting the spirit of that person to come back to the body, the ceremony of lengthening the life, the worshipping candle, “Ched” ceremony, “Hak” ceremony, “Yam Kang” ceremony, “Pao Ha” ceremony, “Kwag Sui” ceremony, and etc (Taoprasert, 2001:2).

Regarding the perception of the people in the northeastern Thailand, the cause of the sickness cannot be explained by only one reason. It may be caused by ghost, magic, superstition, the ending of life, and the consequence of the bad action in the past. Moreover, the cause also relates to the degree of the sickness. For instance, if a sickness of a serious diabetic patient is diagnosed as a result of the ghost of paddy field’s action, the action of paddy field ghost is more important in treating the sickness. Thus, the sickness for the northeastern people means more than a disease, while the disease is the only cause of the problem. In the culture of medical treatment, the disease classification relates to the treatment process and the degree of the disease. Thus, disease are divided into the disease which causes people death and cannot be treated, the general disease which everyone can get and is treatable, the disease which has to be treated in the hospital by operation and injection, the disease which should be treated by the folk medical treatment, the disease concerning the genetics, the disease which happens only with children and old people, and the disease caused by the seasonal change (Nanthabuth, 1999: 30).

Ittijarujul and Pooranan (1990: abstract) studied the “culture and belief of health and sanitary” in 177 cases, including people in the central, southern, northern, and northeastern Thailand by applying the anthropological research methodology. They discovered several supernatural beliefs among people, both Thai-Buddhist and

Thai-Muslim. For instance, people believe that if they pay a respect to the spirit of the house, they will not get sick; prayer makes people become more relieved and relaxed and that has a positive impact on the physical condition. The unlucky person should put the golden leaf on their forehead. On the Buddhist Sabbath day, people should stop working to prevent their body from being injured. People should keep their house clean, since it would bring them prosperity. The southern people eat the fresh opium leaf to maintain the good health. According to the interviews, the folk medical healer can be classified into different patterns: the herbal medical healer, midwife, folk orthopedic healer, massage healer, bowing healer, pediatric healer, ophthalmic healer, healer who helps in averting a catastrophe by a magic means, and fortune teller. In the process of this treatment using the supernatural power, people usually use the magic wording with the boiling herbal water as well as the oil in massaging and fixing the broken body part.

According to the same research, there is a conclusion that there are several beliefs existing in community. The folk medical healers play a major role in maintaining and transferring the belief. The trend of the belief of people changes, due to the economic and social conditions. The conventional medicine becomes more accepted, but the process of change happens slowly.

### **Complementary and alternative therapy**

World Health Organization defines 'health' as the condition of well-being in all aspects including physical, mental, and social ones. This does not only cover the absence of physical and mental sickness but also further beyond. Health depends on three relating factors in three dimensions i.e. biological dimension, psychological

dimension, and social dimension. (Vasee, et al., 1993: 53). These three factors are interrelated. The strong feeling of being healthy will occur only when those three dimensions are in balance and harmony (Capra, 1996: 84). As such, the conventional medicine chiefly focuses on explaining particular system of organs under certain circumstances but fails to describe the holistic and dynamic relation of human body. This is because the biological dimension is seen rather static, but psychological and social dimensions rapidly change (Vasee, 1989: 2-8). The attitude towards health without psychological and social dimensions cannot respond to the need of patients in all dimensions.

Due to its limitations, current mainstream medicine cannot respond to the problems of patients and related parties in all dimensions. Thus, World Health Organization offers the new prospect focusing on the possibility of other medicines that can be supplementary or compensate the parts being missed or incomplete. The strength of this kind of medicine is the holistic healthcare (The public health policy group in socio-cultural aspect, 2000: 18).

‘Alternative health’ and ‘Alternative medicine’ are the words being used to define the healthcare techniques or other medical treatments. Canadian Holistic Medical Association defines ‘Alternative medicine’ as ‘the words adopted by average person or person in medical profession to refer to any other medical technique or treatment that is not widely acknowledged or accepted by medical professions, especially by conventional medicine. These treatments include the usage of natural herb, acupuncture, homeopathy, Reiki, etc. These techniques generally treat patients in ‘non-invasive’ way or ‘do not use chemical-based pharmaceuticals (Cited in The public health policy group in socio-cultural aspect, 2000: 1).

Tantipidok, et al. (2001: 8) points out that the meaning of 'Alternative health' include lifestyle, dietary, working, resting, dwelling, social relations, administration related to personal health, community, and society. When comparing this body of knowledge with practice of mainstream medicine, it could be seen that Alternative health relates to social movement such as various health-concern communities. This word in turn covers wider than alternative medicine. (This more relates to popular sector than professional sector.)

However the terms 'alternative health' and 'alternative medicine' are not well accepted in Asian countries with their own roots of knowledge and practice or the pattern of healthcare as they were the mainstream in the past time. These medicine techniques run parallel with the current mainstream medicine until now. This happens in many Asian countries including China, India, Japan, Tibet and etc. Because this definition takes western tradition of medicine as a prime and other medicines as alternatives, recently the society tends to see more that all medicines existing in society are equally alternatives with their own strengths and weaknesses. In Thailand, it is still much controversial and disputed among certain groups of people if one is about to use this word to include Thai traditional medicine which is not mainstream medicine of society or developed in parallel and equal manner as other western medicine.

'Alternative medicine' refers chiefly to therapy by science or body of knowledge, which requires systematic training and service by professionals. And such a body of knowledge and practice are not in the system of mainstream medicine (related to professional sector).

Besides, there are terms for medicine or science or certain techniques of science of performing healthcare with similar meanings such as unorthodox medicine, non-conventional medicine, holistic medicine, traditional medicine, ethnomedicine, and natural medicine, etc.

Alternative health is therefore healthcare method adopting principle of nature and healing the whole body, mind, and spirit in harmony with one's society and culture. The general strength of alternative health is holistic care. Alternative health can be developed into holistic health development as follows:

1. Alternative health, especially eastern traditional medicines i.e. Chinese, Tibetan, Ayurveda, are all based on the same philosophy, same diagnosis theory, and holistic treatment, concentrating on the physical, mental, and spiritual development and other surrounding factors.
2. Many alternative health sciences offer the principle that every part of the whole body is connected and related. Any treatment on certain part definitely has impact on other parts. For example, in Chinese medicine theory, ears, palms, and feet are centers of nerves of the whole body related to all organs from brain to feet. This also applies to Reflexology and Iridology, whose systems of relation are not yet explainable by the current science.
3. Many alternative health sciences, such as Eastern traditional medicine, Macrobiotics, etc., assume that the good health only comes from the balance in the mind and the body. The true sickness is caused by the imbalance of the whole body and the symptom shown in particular part, or mental tension. The imbalance of the mind and the body can also cause sicknesses such as stomach and heart disease. Or even some opportunistic infectious diseases are resulted from the weakness of the

whole body and the immune system. This gives chance for the disease to develop. This therapy then stresses on rehabilitating and supporting the balance and harmony of the body, the mind, and the nature. The right beginning is to consume healthy food. In this case, the healthy food refers to food that is in harmony with the nature of human and can create equilibrium at the most to the body.

4. Although some alternative health techniques are specific techniques, but they are rooted in eastern traditional medicine, local medicine, and local ethnic medicine from around the world. Most of them are nature-oriented methods such as cooking recipes, herbal usage, and aquatherapy, etc. Many techniques stress on the balance adjustment of life force and self-stimulation for self-recovery in order to create the immune by the nature to fight illness such as Yoga, Homeopathy, different techniques to stimulate biomagnetic power in the body, etc. This includes the chief focus on the balance of the mind that could affect the immune system resulting in healing of the sickness such as meditation, various mind/body-controlling systems.

5. Alternative health techniques, although various in terms of their stresses, complement one another, and any part is indispensable. Those therapists understand well the holistic aspect of therapy. They then generally advise patients to have holistic healthcare too. For example acupuncture therapist realize that the patient could truly recover only by the change of dietary regimen and the campaign of physical exercises such as Yoga practice, Tai Chi, or meditation. If there is no such changes in lifestyle, the well circulating power can be again blocked. In the same way, body/mind control therapists and homeopathy providers also consider that organic food, physical exercise, and mind purification could enhance the ability to recover and to sustain good health.

According to holistic health, there was a previous study which investigated the phenomena of doing well in 16 AIDS patients. They found that seven process categories were used to achieve a general sense of well-being which reflected holistic health such as acceptance, being active, being positive, mastery living, participation in healthcare, experiencing support, and relating mind and body. Relating mind and body is a belief about mind – body relationships which based on the assumption that healing comes from within and is reflected in a group of techniques, collectively termed healing rituals, including visualization, relaxation, imagery, meditation, and affirmation (Gloersen, et al, 1993 : 44-58 ).

National Center for Complementary and Alternative Medicine (NCCAM) and National Institute of Health, USA (1992) have developed the categories of sciences and techniques of alternative health as a guideline for granting research budget (cited in public health policy group on socio-cultural aspects, Office of Public Health Policy and Planning, 2000: 5-7). as follows.

1. Alternative Systems of Medical Practices refer to the science rooting from the local therapy at the self-care level and alternative traditional medicine. Alternative medical systems involve complete systems of theory and practice that have evolved independent of and often prior to the conventional biomedical approach. Many are traditional systems of medicine that are practiced by individual cultures throughout the world, including a number of venerable Asian approaches.

2. Bio-electromagnetic applications refer to the science on the relations between living creatures and electromagnetic field, and electromagnetic field in human body. Energy therapies focus either on energy fields originating within the body (biofields) or those from other sources (electromagnetic fields) such as crystal

therapy (The use of stone and crystals with chakra balancing and color therapy. Crystals, like the human body, are known to have electromagnetic energy. They emit vibrations and frequencies that have the very powerful potential to affect the whole being body, mind, and spirit).

3. Diet, Nutrition, and Lifestyle Changes refer to the sciences using dietary and nutrition to prevent illness, maintain good health, and heal chronic diseases such as macrobiotic (diet composed of: 50% by volume whole grain cereal; 20%-30% vegetable; 10%-15% cooked beans or seaweed; and 5% miso (fermented soy paste). This diet is very low in fat and high in bulk) and Cheewajit (The main idea including use of natural diet for healing combined with complementary therapy i.e. western medicine, macrobiotic, Chinese medicine, herb, yoga, manual healing, etc).

4. Herbal Medicine refers to herbal plants or products from herbal plants that can be used as medicine deriving from ethnic medicine or local wisdom.

5. Manual Healing refers to the science of touching or using hands as a tool to diagnose and heal such as massages therapy and reflexology.

6. Mind/Body Control refers to the sciences focusing on the potential healing power of the mind. Most of these techniques are derived from traditional medicine and utilizing relation of the body and the mind such as meditation and prayer.

7. Pharmacological & Biological Treatments refer to the sciences using medication and vaccines, which are not accepted by the mainstream medical professions.

As for sciences of alternative health in Thai society, the evaluation of public and private health operation by Office of Public Health Policy and Planning during

October, 1997 not including Thai traditional medicine, local medicine or the medicine of local ethnic groups in Thailand, shows that there are least 38 sciences/techniques of alternative health from other societies and cultures entering Thailand, and 35 categorized alternative health sciences/techniques are currently at service and offer medical services. They can be categorized as follows:

1. Sciences/techniques of traditional medicine apart from Thai traditional medicine and Thai herbal medicine which are already popular. There are some other traditional medicines from other societies which also gain popularity:

1.1 Chinese medicine including diagnostic techniques of sensing pulse, examining the balance of Yin-Yang force and elements, Acupuncture, Acupressure, Reflexology, Herbalism, and various kinds of physical exercise such as Tai Chi, Qi Kong etc.

1.2 Indian medicine techniques such as Ayurveda, the famous Yoga practice, Chakka breathing/Chakka healing, fasting, and Rajah Yoga focusing on the balance and the harmony with nature.

1.3 Some other eastern medicine techniques such as life energy, and So-Tai from Japan.

2. Sciences relying on the principle of creating the balance of bioelectromagnetics in the body to cure. Those are found in Thailand such as the uses of biospectrum, electromagnetic field, electrostimulator, electro-neuromagnetic stimulator, universal energy, and Yore.

3. Sciences of structural and energetic therapy such as the therapeutic techniques for structure (skeleton, muscle, and tendon) to balance life force. Those found in Thailand apart from Chinese and Indian physical exercises are some western

natural healing techniques found such as Chiropractic, Carnio-Sacral Therapy, Aquatic exercise, Hot-Cold Therapy, Hydromassage, Hydrotherapy, Kinesiology, other cultures' massage (unidentified and perhaps mixed with Thai massage), Therapeutic massage, Myofacial release, massage relaxing techniques, solar Bath, and other natural therapies.

4. Sciences of diet, nutrition, and lifestyle focusing on the changes in consuming behavior, and food and nutrition supplement. Those found in Thailand can be categorized as follows:

4.1 Health promotion and healing by food such as diet/nutrition therapy, nutrition supplement, vitamin therapy or megavitamin therapy or orthomolecular, juice therapy.

4.2 Changes in lifestyles and new consuming behaviors such as macrobiotic food and lifestyles, vegetarianism, natural foods and products.

4.3 Healing techniques specialized in the digestive system such as colon therapy, detoxification, and fasting.

5. Sciences of Body/Mind control focusing on the importance of the relation between body and mind. Physical and mental health promotion, mental therapy, and physical illness related to mental disorder found in Thailand can be categorized as follows:

5.1 Existing techniques in current mainstream medicine such as counseling, relaxation, and Psychotherapy.

5.2 New alternative techniques such as meditation, aroma therapy, art therapy, music therapy, breathing pattern technique, hypnosis, humor therapy, guided imaginary, and Yore.

6. Sciences of Bio-Treatment using biological and organic substances to heal and promote health such as Thai, Chinese, and Indian herbalism; and anti-oxidizing agent such as ozone, bio-oxidative medicine, homeopathy, and urine therapy.

In Thailand there was a survey on the premises offering alternative health care service to HIV/AIDS patients in 1999. The findings showed that governmental unit, private units, and religion related units in service for AIDS patients can be classified into four aspects. First, Nutrition aspect is vegetarianism, Cheewajit food, and others such as local food, natural/organic food, herbal food, Dhammarak food, food supplement of Wat Phra Bata Num Phu and health food, vitamins and minerals, food complying with element principles, and exemption of taboo food. Second, physical exercise or physical structure adjustment aspect includes the most popular Thai traditional massage, herbal steam, herb warm compress ball, yoga, Qi Kong, Tai Chi, and the use of bioelectric field. Third, mental exercise aspect means to encourage and raise morale. This includes meditation, music therapy, handcraft and art therapy, and relaxation program of Department of Mental Health. Finally, herbal therapy includes single herb and formula herb uses, biospectrum, Dhammachakra life force, health group, stimulating acupuncture, blocking acupuncture, and electric massage device.

### **Related factors influencing the decision to use complementary and alternative therapy**

O'Connor (1995:165) proposed that conditions under which alternative healthcare measures are most likely to be used are as follows.

1. Serious, chronic, debilitating, or terminal illness, especially when conventional medicine has limited success in controlling symptoms or disease processes. (Examples: HIV disease, chronic fatigue syndrome [CFS], multiple sclerosis [MS], auto-immune disorders, cancers)
2. Acute or chronic conditions for which conventional medicine has little or nothing curative to offer. (Examples: headache, persistent back pain, various skin conditions, colds, allergies, fatigue, weight control, asthma, rheumatic diseases, pain syndromes)
3. Conditions for which a person prefers non-drug, noninvasive approaches, and which have popular reputations for non-medical management success. (Examples: insomnia, allergies, colitis and other disorders of the digestive system, pregnancy and childbirth, asthma, headache, back pain, arthritis)
4. Desire to replace recommended medical therapies that are offensive or impair quality of life, or with which a person disagrees. (Examples: invasive therapies, drugs with significant toxicity, disfiguring treatments, drugs with mood-altering or sense-altering side effects, extended or lifelong regimens)
5. Need to control side effects of conventional medical therapies (while not wishing to discontinue the therapies).
6. Dissatisfaction with treatments, outcomes, or personnel and attitudes of conventional medicine.
7. Failure of conventional therapy.
8. Inability of physicians to arrive at a diagnosis, especially after lengthy efforts or exhaustive testing.

9. Diagnoses that are too vague, that are offensive to the patient, or with which the patient disagrees. (Examples: persistent “fever of unknown origin” [FUO]; illnesses in which mental illness or psychosomatic processes are considered to be sole or contributing factors)

10. Illnesses that conventional medicine does not recognize as diagnostic categories. (Examples: folk illnesses, new diseases, e.g. CFS)

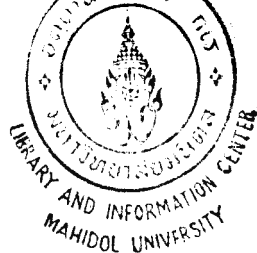
11. Instances in which conventional medicine is considered to be addressing symptoms, but not underlying causes. (Examples: allergies, digestive disorders, illnesses in which spiritual or supernatural causal factors are implicated from the patient’s point of view)

12. Instances in which conventional medicine is felt inadequate to address a person’s health concerns. (Examples: nutrition, prevention, health maintenance or promotion of “wellness,” preference for natural rather than synthetic medicaments, preference for high patient involvement in determination of therapeutic course)

13. Whenever a particular health belief system is part of a person’s cultural heritage or identity-group culture, or part of a consciously chosen lifestyle.

Based on the literature review, it is obvious that generally there are studies on the relationship of psychosocial factors and the choice of complementary and alternative therapy. For example, Singh, et al (1996) studied determinants of non-traditional therapy use in 56 patients with HIV infection and found that age, membership of Aids social network, high social support, and being active in coping with the illness are determinants to use complementary and alternative therapies.

Ostrow, et al (1997:115-119) studied determinants of complementary therapy use in HIV-infected individuals receiving anti-retroviral or anti-



opportunistic agents and found that age, high income, high education, and pain are determinants to use complementary and alternative therapies. Similarly, the study of Duggan (2001:159-166) found that using complementary and alternative therapies was determined by high education. While Fairfield (1998: 2257-2264) found that complementary and alternative therapies uses are correlated with fatigue, memory impairment, and weight loss.

Knippel (2000: 435-444) explored folk medicine use in 70 patients with HIV infection and found that 70 percents of the patients used folk medicine with conventional medicine correlated with low pain, and active to cope with illness. This finding was different from that of Ostrow, et al. (1997: 115-119) who found that pain was a determinant of complementary therapy use.

In domestic research field, Boonjaipecth (1983) conducted a comparative study of socio-psychological factor of patients obtaining services from traditional treatment and conventional treatment. The finding indicates that patients obtaining traditional treatment and conventional treatment have significant differences in terms of statistics over the matters of the original belief, the worry over expense of conventional treatment, the failure of conventional treatment, and the attitude toward the herbal use of traditional treatment. Most of the patients admitted that traditional treatment is effective but can only heal certain illnesses such as orthopedic illness, paralysis, and some chronic diseases. Many sicknesses are much effective when treated in conventional way.

Nanethong (1991: 198) explored behaviors of choosing local traditional medicine and conventional medicine. The findings showed that the motives of patients' seeking traditional treatment are belief of the cause of sickness, black magic,

treatment, the fear and incomprehension of the conventional treatment, financial problem, and the faith in effectiveness of the traditional treatment.

Samrongthong (1996: 121) surveyed the concept of explaining diseases, personal behavior, and the search for treatment of 28 HIV/AIDS patients in a Buddhist monastery. The study showed that social network plays an important role in making decision on illness and treatment. The social network refers to father, mother, siblings and relatives, and peer group.

Antarasen (1997: 100-102) studied the system of Thai traditional medicine service in the province of Songkla. The study showed that the factors leading patients to the service are the expectation of Thai traditional treatment, the satisfaction on the effectiveness of the treatment, the quality of service providers, chronic disease, and the belief that certain sickness must be cured only by Thai traditional medicine.

Chanrit (1999: 86-89) studied the use of Thai traditional medicine in community hospital in the province of Nakorn Sawan. The finding showed that the factors leading patients back to follow-up treatment are the satisfaction to quality of service, the suitable level of cost, long duration of sickness, and the satisfaction with service providers.

Somboonburana (1999: 122) conducted a study on the factor leading to changes in personal healthcare behaviors by the principle of 'Cheewajit.' The findings showed that the supportive factors effecting the decision to change personal healthcare behavior can be divided into three aspects: information intake, recognition and realization of the importance of healthcare, and the convenience to comply with 'Cheewajit' principle and adapt to everyday life.

On the qualitative research side, Pawluch, et al., (2000: 251-263) studied lay constructions of HIV and complementary therapy use in 66 HIV/AIDS patients by means of qualitative analysis. Results of the study represented different things for each patient such as complementary therapy is a health maintenance strategy, a healing strategy, an alternative to western medicine, a way to mitigating the side effects of drug therapies, a strategy for maximizing quality of life, a coping strategy, and a form of political resistance. These individuals' meaning ascribe of complementary therapy may change over time and be linked to social characteristics including sexuality, ethnocultural background, gender, beliefs about health and illness, values, and experiences.

From this study, Pawluch also found out that definitions of complementary therapy in AIDS patients are dynamic and inconstant. They much depend on internal and external factors of certain persons. Therefore, to understand how AIDS patients define 'complementary therapy' is to understand two key points of 'who' that person is and 'what' is that person's social context.

### **Complementary and alternative therapy in HIV/AIDS patients**

At the international level, the complementary and alternative therapy is very popular. According to the study of Eisenberg, et al. during 1990-1996, the people of the United States used at least 1 of 16 sorts of complementary and alternative therapy increasing from 33.8% in 1990 to 42.1% in 1996. The sorts of complementary and alternative therapy gaining increasing popularity are herbal medicine, massage, megavitamins, support group, local medicine, healing power, and Homeopathy.

Fairfield, et al. (1998: 2257-2264) explored complementary and alternative therapy use in 180 HIV/AIDS patients and found that 67.8% of the sample used herbal medicine, vitamin, and nutritional supplements, while 45% visited complementary and alternative medicine provider, making median of 12 visits per year.

Green, et al. (1999: 60-69) explored complementary and alternative therapies use in 1,016 HIV/AIDS patients and found that 64 % of the sample used aerobic exercise, 56% used prayer, 54% used massage, 48% used acupuncture, 46% used meditation, 42% went to support group, 34% used imaginary, and 34% used breathing exercise.

Duggan, et al. (2001: 159-166) explored complementary and alternative therapies use in 191 AIDS patients. The study revealed that the most popular complementary and alternative therapies are exercise (43%), changes in lifestyle (38%), nutritional supplement (37%), counseling (27%) herbal use (26%), and megavitamin and prayer (24%).

In Thailand, Saengchart (1997: abstract) studied the culture of self-care among AIDS patients in the northeastern region of Thailand by using a qualitative method on the group of 30 subjects. The research showed that culture of self-care behaviors in part of complementary therapy consisted of three tactics: promoting health, disease prevention, and symptom management. Most of them (80%) used herbal medicine, traditional formula of medicine (43.33%), holy water (63.3%), exorcism (30%), exercise (26.67%), magic and past life correction (23.33%), and trial of new methods by themselves (16.67%).

Pavanapron & Chancharoen (cited in Tantisak & Permpornkul, 2000: 20) studied the health promoting behaviors of AIDS patients in governmental hospitals in Complete and Continuing healthcare service system for AIDS patient project (1997). The study showed that most patients took care of their health by seeing physicians and taking medication as prescribed (96.7%). At the same time, patients also took care of their health by some other means as well such as herbal medicine, exercise, meditation, and consuming health food.

Sirisernwong, et al. (cited in Tantisak and Permpornkul, 2000: 20) explored the use of herbs to treat AIDS patients and cancer patients. The research indicated that 79.8% of AIDS patients used herbs along with conventional medication. The length of usage was less than a year for 79.81%. The patient with full-blown AIDS accounted for 57.1%.

The study of Muenhas & Pinitluek (abstract, 2001: 344) presented at The 8<sup>th</sup> National Seminar on AIDS was on the self-care and health promotion by complementary therapy of 86 AIDS patients in the province of Khon Khaen. The study revealed that 55.8% of the patients employed the complementary therapy. The most popular sorts of complementary therapy were herbal use and exemption of taboo foods.

In literature review on the efficacy of complementary and alternative therapy, Fairfield, K. M., et al (1998: 2257-2264) surveyed the complementary and alternative therapy on the aspects of expense and effectiveness recognition of 180 HIV patients. The survey suggested that in terms of effectiveness recognition, the sampling group answered that the complementary and alternative therapy helped at

the 'good' level to 'the most,' and 81% used food supplement, 76% sought help from therapist, and 87% of the patients with marijuana consumption records.

LaPerriere, et al. (1997) conducted a literature review regarding the effect of exercise on immune parameters in HIV-positive individuals. Evidence in the existing literature demonstrated that the stress management role of exercise training induced a return of CD4 counts to more normal levels. The available literature also revealed no decline in CD4 counts in any study, regardless of disease stage. Furthermore, CD4 counts exhibited a trend of increasing, especially participants at the early stage of the disease (LaPerriere, et al., 1997; cited in Greene, et al., 1999:62).

Ironson, et al. (1996) carried out randomized, controlled clinical study in 29 HIV positive men. They found a significant increase in some immunologic markers except CD4 and CD4+/CD8+ lymphocyte ratio. However, they found a significant decrease in anxiety level and stress hormone level as well as an increase in relaxation for participants receiving massage (Ironson, et al., 1997; cited in Greene, et al., 1999:64).

Chongsathitman (1995: abstract) conducted research on the meditation for healing AIDS patients at Wat Doi Geng, the province of Mae Hong Son. Monks trained various meditation techniques to patients together with positive thinking toward AIDS. This aimed to drive any bad matters out of the body by mediation and to deploy mechanism of healing by creating natural human immune system. After the end of Dhamma course, the fastest and the biggest impact was mental health. This reduced worry and restlessness. This also gave physical result by reducing or stopping symptoms such as weight loss, fatigue, loss of appetite, herpes zoster, lymphadenopathy, and fever. The long-term effect depended on many factors i.e.

social support, acceptance from family and society, exemption from negative view when performing Dhamma and meditation, and the absence of seduction to violate.

Pathummanont (1998: 83-85) carried out research on the effectiveness of holistic treatment in self-care and quality of life of AIDS patients. The research revealed that after obtaining holistic nursing including education on holistic healing and self-care such as consuming health foods, exercise, relaxation, various techniques of mental training along with evaluation, and regular home visiting over the duration of 6 months, the result was that the experimenting group with holistic nursing had a higher level of quality of life compared with the control group at the statistically significant level.

In conclusion, the review of literature shows that the complementary and alternative therapy is a part of self-care behavior of HIV/AIDS patients, which cannot be solely explained by physical dimension. The continuing phenomena are accumulating and developed from popular sectors. With the special characteristic of the system that gives meanings of existing health related behaviors, various concepts of disease and treatment occur. These concepts constantly change according to the inflow of information in the system, along with dynamic psychosocial context resulting in changes of self-care behavior under the pluralistic character of the healthcare system as a whole. However, apart from the literature reviewed in this chapter, no literature on the reason of employing the complementary and alternative therapy is found, neither is the indicator to evaluate effectiveness according to the perception of HIV/AIDS patients.

## CHAPTER III

### MATERIALS & METHODS

The purpose of this descriptive research was to explore sort of complementary and alternative therapy use in HIV/AIDS patients, the reason for using complementary and alternative therapy, the indicator which HIV/AIDS patients used to evaluate the efficacy of complementary and alternative therapy, the level of efficacy that they perceived, resources of information and the expenditure of complementary and alternative therapies use of HIV/AIDS patients. The research design, the subject of the study, the research instruments, data collection, as well as the data analysis are presented in this chapter.

#### **Population and subject**

The target population of this study was HIV/AIDS patients from the Out-Patient Department of Medicine at Ramathibodhi Hospital. The subjects were selected for this study by using purposive sampling methodology. The subjects were recruited based on the following inclusion criteria:

1. Being 15 years of age or over;
2. Being Diagnosed by the physicians to be infected with HIV and having been informed about the diagnostic result for at least 8 weeks, at whatever stage of the disease;
3. Having good consciousness and possessing speaking ability in Thai;
4. Being willing to participate in this study;

5. Going on foot to the Out-Patient Department of Medicine or being transferred by wheelchairs.

The average number of HIV/AIDS patients who went to the OutPatient Department of Medicine at Ramathibodi Hospital from 1998 to 2001 was 1,139. Considering the number of the population, it was not more than one thousands. Hence, the subject size was calculated from 10% of the population (Prakong Karnnasuth, 1981 cited in Yuwadee Luecha, 1997), totaling 114 patients.

### **Setting**

The setting of this study was the Out-Patient Department of Medicine at Ramathibodi Hospital. The general clinic provided care for persons with HIV/AIDS everyday from Monday through Thursday from 9:00 a.m. – 12:00 p.m. and specialty clinic on Friday from 9:00 a.m.- 12:00 p.m. The patients who visited the clinic could see the physician and receive health education from nurses if they needed or the medical doctor referred them.

### **Interview forms**

The interview forms used in this study were the semi-structured open-ended interview forms, which consisted of the information as follows:

1. Part I: The demographic information related to the characteristics of the patients which consisted of the information about the patient's sex, age, marital status, religion, income, education, occupation, residence, home town, source of payment support, and membership of the AIDS social network.

2. Part II: The basic information about illness and treatment which consisted of length of time after the diagnosis, stage of the disease, anti-HIV drug treatment, number of admissions in the hospital, opportunistic infection, and complementary and alternative therapy used.

3. Part III: The interview form which consisted of sorts of complementary and alternative therapy which the subjects used.

4. Part IV: The interview form which was developed by the researcher consisting of the questions covering the patients' reasons in making decisions to use complementary and alternative therapy, sources of information about complementary and alternative therapy, the indicator which HIV/AIDS patients chose to evaluate the efficacy of the complementary and alternative therapy, including the level of efficacy they perceived and the expenditures they had paid per month for each sort of complementary and alternative therapy they used.

#### **Validity testing of the interview form**

The researcher conducted a pilot study of 11 HIV/AIDS patients who had the same characteristics the targeted subjects based on the inclusion criteria to test the validity of the semi-structured open ended interview forms. The interviewing technique had been commented and suggested by the major advisor. The questions were adjusted and corrected for completeness of the data before being used in this study.

## Data Collection

Data collecting was carried out in the following sequence:

1. Screening for eligible subjects based on the inclusion criteria was conducted at the Out Patient Department of Medicine, Ramathibodi hospital, Mondays to Fridays from 9:00 a.m. to 12:00 p.m.

2. All eligible subjects were approached after they met the doctor. Before the data had been collected, the study objectives were explained to the subjects, as well as expected outcomes, data collection processes, and the rights of the subjects to participate in this study.

3. The subjects who were willing to participate in the study were interviewed based on the interview forms:

3.1 The demographic data of the patients which consisted of information about sex, age, marital status, religion, income, education, occupation, present home address, hometown, residence's characteristics, resources for hospital payment, and membership of the AIDS social network.

3.2 The basic information about illness and treatment which consisted of length of time after the diagnosis, stage of the disease, anti-HIV drug use, number of admissions in the hospital, opportunistic infection, and complementary and alternative therapy used.

3.3 The subjects were then interviewed about sorts of complementary and alternative therapy being used, the reason of its use, and the indicators used to evaluate its efficacy. For perceived efficacy of complementary and alternative therapy, The subjects were asked to rate the scores. The possible scores

ranged from 0 to 10. Ten points meant that the sort of complementary and alternative therapy used was the most helpful practice for them to decrease their symptom severity, while zero point meant that the sort of complementary and alternative therapy had no usefulness for them to relieve their symptom severity. Finally, the researcher asked the subjects whether the content was clear with the researcher's purpose of preventing the data-error caused by miscommunication.

### **Data Analysis**

In this study, descriptions of the subjects and the use of complementary and alternative therapy were reported in detail by using descriptive statistics including frequency, percentage, range, and mean.

## CHAPTER IV

### RESULTS

The findings of the study are presented in this chapter. The demographics data of the patients are described. The answers to the five research questions are presented. The questions are 1) What are the sorts of complementary and alternative therapy used by HIV/AIDS patients? 2) What is the reason for using complementary and alternative therapy of HIV/AIDS patients? 3) What is the original source which leads the patients to use each sort of complementary and alternative therapy, and what are sources of information about complementary and alternative therapy used by HIV/AIDS patients? 4) What is the indicator used to evaluate the efficacy of complementary and alternative therapy of HIV/AIDS patients, and what is the level of efficacy which they perceive? 5) How much is monthly expenditure which HIV/AIDS patients pay for each sort of complementary and alternative therapies?

#### **Description of population**

In this study, the data were collected by interviewing HIV/AIDS patients who came to a follow-up at the Out-Patient Department of Medicine at Ramathibodi hospital from June to August 2002. All subjects were interviewed by the researcher. Most of the interviews took about 25-40 minutes, while some cases took time longer than 40 minutes because the subjects would like to discuss about their self-care behaviors. Based on the inclusion criteria, there were 115 subjects who were eligible for this study.

Table 1. Number and percentage of demographic characteristics of the subjects  
(N=115)

Demographic characteristics	number	percent
Sex		
Male	68	59.1
Female	47	40.9
Age (years)		
21-30	26	22.6
31-40	65	56.5
41-50	19	16.5
51-60	5	4.3
(Mean = 35.9; SD=7.7; Range=21-60)		
Religion		
Buddhism	115	100
Marital status		
Single		
Male	27	
Female	3	
Total	30	26.1
Married		
Male	33	
Female	26	
Total	59	51.3
Widow		
Male	1	
Female	10	
Total	11	9.6
Divorced / separated		
Male	7	
Female	8	
Total	15	13.0
Educational background		
No education	3	2.6
Primary School	44	38.3
High school	23	20.0
Certificate & Diploma	27	23.5

Table 1 (continued) Number and percentage of demographic characteristics of the subjects (N=115)

Demographic characteristics	Number	Percent
Bachelor's degree	17	14.8
Master's degree	1	0.9
Occupation		
Unemployed	22	19.1
Student	1	0.9
Employee	51	44.3
Agriculturist	4	3.5
Trader	19	16.5
Business owner	2	1.7
Government officer	14	12.2
Lawyer	1	0.8
Housewife	1	0.8
Income (Baht)		
No income	15	13.0
Less than 4,000	12	10.4
4,001-8,000	43	37.4
8,001-12,000	21	18.3
12,001-16,000	8	7.0
16,001-20,000	11	9.6
More than 20,000	5	4.3
Present Address		
Bangkok	64	55.7
Other province	51	44.3
Hometown (divided by region)		
North	18	15.7
Central	50	43.5
Norths-east	36	31.3
South	11	9.6
Residential characteristic		
Own house	47	40.9
Living with relatives	14	12.2
Friend's house	2	1.7
Rent	37	32.2
Welfare house	14	12.1
Temple	1	0.9
Resources for hospital payment		
Self-paid	13	11.3
Family	21	18.3
Relative	13	11.3
Friend	3	2.6

Table 1 (continued) Number and percentage of demographic characteristics of the subjects (N=115)

Demographic characteristics	Number	Percent
Reimbursement	21	18.3
Social service	4	3.5
Social insurance	21	18.3
Government insurance	18	15.7
Employer	1	0.9
Membership of the AIDS social network		
No	110	95.7
Yes	5	4.3
CAT* using		
No	16	13.6
Yes	99	86.1

Note CAT\* refers to complementary and alternative therapy

#### Demographic characteristics

The demographic characteristics of the subjects are shown in Table 1. In terms of sex, 59.1% were male and 40.9% were female. Their age ranged from 21 to 60 years. The mean age and standard deviation were 35.9 and 7.7 years, respectively. A total of 115 subjects were Buddhism. The largest group of subjects were married (51.3%). The largest group of them had finished primary school (38.3%), followed by certificate or diploma (23.5%) and a bachelor's degree (14.8%). Almost half of the subjects were employees (44.3%), followed by being unemployed (19.1%), traders (16.5%), and government officers (12.2%). The largest group of them had income between 4,001-8,000 baht per month.

The present address of more than half subjects 55.7% was in Bangkok, while 44.3% lived in other provinces. Close to half of them lived in their own houses (40.9%), followed by a rented houses (32.2%). The hometown of the subjects, 43.5%

was in the central region, and 31.3% came from the northeast region. Regarding resources for hospital payment, most of them received support either from family, social insurance, or reimbursement (18.3% each). Only 5 subjects (4.3%) were a member of the AIDS's social network. Finally, the majority of the subjects (86.1%) used complementary and alternative therapy.

### Illness history

As shown in Table 2, the largest group of the subjects (47%) were in the symptomatic stage, followed by asymptomatic stage (31.3%), and full-blown AIDS (21.7%). Close to three-quarters (64.3%) had been diagnosed with HIV infection for more than 1 year. Of 65 (56.5%) received anti-HIV drug, never admitted in a hospital (79.1%). The largest group of subjects had no opportunistic infection (70.4%), while 9.6% were infected with tuberculosis, 5.2% herpes zoster, 4.3%CMV retinitis and another 4.3% cryptococcal meningitis equally 4.3%, 3.5% pneumocystic carinii, and 0.9% mycobacterium avium complex and toxoplasmosis equally.

Table 2. Illness history of the subjects

Characteristics	number	Percent
Time duration since diagnosis		
Less than 6 months	10	8.7
6 months –12 months	31	26.9
More than 12 month	74	64.3
(Mean = 38.46; SD = 37.68; Range = 3 –156)		
Stage of disease		
Asymtomatic	36	31.3
Syntomatic	54	47.0
AIDS	25	21.7

Table 2. (Continued) Illness history of the subjects

Characteristics	number	Percent
Anti-HIV drugs used		
Yes	65	56.5
No	50	43.5
Number of admissions		
Never	91	79.1
1-2	22	19.1
3-4	1	0.9
5	1	0.9
Opportunistic infections/diseases		
None	81	70.4
Tuberculosis	11	9.6
Herpes zoster	6	5.2
CMV retinitis	5	4.3
Cryptococcal meningitis	5	4.3
Pneumocystic carinei	4	3.5
Mycobacterium avium complex	1	0.9
Toxoplasmosis	1	0.9
Psoriasis	1	0.9

### Sorts of complementary and alternative therapy used

As illustrated in Table 3, some patients in this study used more than one sort of complementary and alternative therapies. In particular, 30 subjects (30.30%) used two sorts, followed by 29 subjects (29.29%) used three sorts, 19 subjects (19.20%) used one sort, 17 subjects (17.17%) used four sorts and 4 subjects (4.04%) used five sorts of complementary and alternative therapies.

Table 3 Number and percentage of sorts of complementary and alternative therapies used in each HIV/AIDS patient (N = 99)

Amount of sorts of CAT*	number	Percent
1 sort	19	19.20
2 sorts	30	30.30
3 sorts	29	29.29
4 sorts	17	17.17
5 sorts	4	4.04
Total	99	100.00

\*CAT refers to complementary and alternative therapy.

By applying the NCCAM (1992), complementary and alternative therapies used were categorized in 5 groups: mind/body control, diet/nutrition/lifestyle changes, herbs, manual healing, and energy therapy. According to table 4, the most frequently used complementary and alternative therapies was mind/body control (n=116), followed by diet/nutrition/lifestyle change (n=72), herbs (n=47), manual healing (n=12), and energy therapy (n=3).

Of the 116 cases who used mind/body control strategy, the most frequently used sort of complementary and alternative therapies of the subjects was ritual ceremony (37.93%). Of the 72 cases that used diet/nutrition/lifestyle change strategy, the most frequently used sort of complementary and alternative therapies was avoiding taboo food (38.9%). The most frequency form of herbs used by the subjects was eating (85.1%). Of the 12 cases who used manual healing strategy, most of them used massage (66.67%), followed by reflexology (33.33%). Of the 3 cases that used energy therapy, sorts of complementary and alternative therapies used by the subjects were yore, crystal therapy, and universal energy. In this study, crystal therapy and

universal energy were used together by the same subject. In conclusion, Top ten sorts of complementary and alternative therapies were using herbs (n=47), followed by ritual ceremony (n=44), exercise (n=36), avoidance of taboo food (n=28), nutritional supplement (n=24), meditation (n=19), vitamin supplement (n=17), prayer (n=9), massage (n=8), and reflexology (n=4) and yoga (n=4).

As regards the stages of the disease, of the 71 cases in the asymptomatic stage, 16 cases (22.5%) used ritual ceremony, followed by herbs 15 cases or 21.1%, avoidance of taboo food and vitamin supplement equally in 8 cases (11.3%), nutritional supplement in 5 cases (7.04%) and exercise, meditation, and prayer 4 cases each (5.6%). Of the 129 cases in the symptomatic stage, 22 cases (17.1%) used herbs and exercise equally, followed by ritual ceremony in 21 cases (16.3%), nutritional supplement in 14 cases (10.9%), avoidance of taboo food in 12 cases (9.3%), and meditation in 10 cases (7.8%). Of the 55 cases in the symptomatic stage, 10 cases (18.18%) used herbs and exercise equally, followed by taboo food in 8 cases (14.5%), ritual ceremony in 7 cases (12.7%), meditation and nutritional supplement in 5 cases (9.09%), and vitamin supplement in 3 cases (5.5%).

Table 4 Number and percentage of sorts of complementary and alternative therapies used by HIV/AIDS patients (N = 99)

CAT* using	asymptomatic	symptomatic	AIDS	Total number of subjects N(%)
mind/body control				
Ritual ceremony	16	21	7	44 (37.93)
exercise	4	22	10	36 (31.04)
meditation	4	10	5	19 (16.38)

Table 4 (continued) Number and percentage of sorts of complementary and alternative therapies used by HIV/AIDS patients (n=99)

CAT* using	asymptomatic	symptomatic	AIDS	Total number of samples
				N (%)
prayer	4	4	1	9(7.76)
yoga	2	1	1	4(3.45)
music therapy	1	0	1	2(1.72)
aroma therapy	1	0	1	2(1.72)
total				116(100)
diet/Nutrition/life style changes				
taboo food	8	12	8	28(38.9)
nutritional supplement	5	14	5	24(33.3)
vitamin	8	6	3	17(23.6)
healthy food	1	1	1	3(4.2)
total				72(100)
herbs				
internal use	13	18	9	40(85.1)
local application	1	3	1	5(10.7)
herb warm compress ball	0	1	0	1(2.1)
steam room	1	0	0	1(2.1)
total				47(100)
manual healing				
massage	0	8	0	8 (66.67)
reflexology	1	3	0	4 (33.33)
total				12 (100)
Energy therapy				
yore	0	0	1	1 (1.33)
crystal therapy	0	0	1	1 (1.33)
universal therapy	0	0	1	1 (1.33)
total				3 (99.99)

\*CAT refers to complementary and alternative therapy.

Note: each patient might have used more than one sort of CAT.

### The reasons for complementary and alternative therapy use

Table 5 reveals that the major reason why the subjects used complementary and alternative therapy was symptom distress (42.58%), followed by suggestion from others (34.14%), promoting health (18.88%), their own beliefs (2.40%), try for cure (1.60%), and unaffordable anti-HIV drug (0.40%).

Table 5 Number and percentage of reasons for CAT\* use in HIV/AIDS patients (N=255)

Reasons	Number	Percent
symptom distresses	106	42.58
suggestion from others	85	34.14
promoting health	47	18.88
their own beliefs	6	2.40
try for curing	4	1.60
unaffordable anti-HIV drug	1	0.40
total	249	100

\*Each patient might have used more than one sort of CAT.

\*CAT refers to complementary and alternative therapy.

In cases of symptom distress as the reason to decide to use complementary and alternative therapies, the most frequency symptom distress found in this study was anxiety (44.34%), followed by itching (24.53%), pain (14.15%), anorexia (8.49%), and fatigue (3.77%).

**The original sources leading the HIV/AIDS patients to use each sort of complementary and alternative therapy**

As shown in Table 6, in case of performing complementary and alternative therapy based on the reason about symptoms, most of the original sources that led the patients to use complementary and alternative therapy to manage the symptoms were initiated by themselves (54.05%), followed by the influence of the information received from others (45.95%).

Table 6. Number and percentage of the original source leading to CAT use categorized by sorts of CAT related with symptom distresses

Symptom related with CAT using	Information about CAT received from others	Initiated by themself	Total number	Percent
Anxiety			47	100.00
Ritual ceremony	7	21	28	59.57
Meditation	3	4	7	14.89
Prayer	3	2	5	10.64
Massage	1	3	4	8.51
Music	0	2	2	4.26
Exercise	0	1	1	2.13
Itching			26	100.00
Taboo food	3	19	22	84.6
Local application	3	1	4	15.4
Pain			15	99.98
Herb	5	0	5	33.33
Massage	3	1	4	26.66
Reflexology	2	1	3	20.00
Exercises	0	2	2	13.33
Yoga	1	0	1	6.66
Anorexia			9	100
Vitamin	6	1	7	77.78
single herb	1	-	1	11.11
Formula herb	1	-	1	11.11

Table 6.(continued) Number and percentage of the original source leading to CAT\*  
use categorized by sorts of CAT related with symptom

Symptom Related with CAT using	Information about CAT received from others	Initiated by themselve	Total number	Percent
Fatigue			4	100
exercise	0	2	2	50
nutritional supplement	2	0	2	50
Abdominal discomfort				
Taboo food	1	0	1	50
herb	1	0	1	50
Dizziness			2	100
Aroma therapy	2	0	2	100
Fever			1	100
Herb	1	0	1	100

CAT\* refers to complementary and alternative therapy

The Top five who symptom distresses were anxiety, itching, pain, anorexia, and fatigue. Of the 47 cases who suffered from anxiety, 70.21% initiated complementary and alternative therapy by themselves; the most frequently used sort of therapy was ritual ceremonies. Of the 26 cases who suffered from itching, 76.9% initiated complementary and alternative therapy by themselves; the major sort of therapy was avoiding taboo food. Of the 15 cases who suffered from pain, 73.33% used complementary and alternative therapy because of the suggestions from others; the most frequently used sort of therapy was herb. Of the 9 cases who suffered from anorexia, 88.88% used complementary and alternative therapy because of suggestions from others; the most frequently used sort of therapy was vitamin supplement. Of the

4 cases who suffered from fatigue, 50% initiated complementary and alternative therapy by themselves, while the others 50% listened to suggestions of others; the sorts of complementary and alternative therapy used to manage fatigue were exercise and nutritional supplements.

Table 7 Number and percentage of original sources leading to use of CAT\* regarding sorts of CAT that was used to promote health in HIV/AIDS patients (N=48)

Promoting health	Information about CAT received from others	Initiated by themselves	Total number	Percent
exercises	1	17	18	37.5
nutritional supplements	11	0	11	22.9
vitamins	6	0	6	12.5
herb	6	0	6	12.5
meditation	2	0	2	4.1
reflexology	1	0	1	2.1
Taboo food	1	0	1	2.1
crystal therapy	1	0	1	2.1
healthy food	1	0	1	2.1
universal energy	1	0	1	2.1
total	31	17	48	100

**Note\***CAT refers to complementary and alternative therapy.

As depicted in Table 7, of the 48 cases who used complementary and alternative therapy to promote health, the original sources that led the patients to use complementary and alternative therapy to promote health were the influence of information that they received from others (64.6%) and own initiation (35.4%). The only one sort of complementary and alternative therapy initiated by themselves to promote health was exercise.

Table 8 Number and percentage of sources of information about CAT used by HIV/AIDS patients (N=162)

Sources of information	Number	Percent
Family/relative	44	27.2
Media	38	23.4
Friends	29	17.9
Health personal	22	13.6
Neighbor	12	7.4
Drug store	11	6.8
AIDS social network	5	3.1
Direct sale	1	0.6
Total	162	100

**\*Note** Each HIV/AIDS patients might have used more than one sources of information about CAT.

As can be seen in Table 8, the most important sources of complementary and alternative therapy information that the subjects received were from family or relatives (27.2%), followed by media (23.4%), friend (17.9%), health personnel (13.6%), neighbors (7.4%), drug stores (6.8%), AIDS social network (3.1%), and direct sales (0.6%).

Table 9 Number and percentage of sorts of media used by HIV/AIDS patients

Media	Number	Percent
Television	15	39.47
Magazine/pocket book	10	26.32
Radio	7	18.42
Newspaper	4	10.53
Poster	2	5.26
Total	38	100

As table 9, in term of media, television was the important media which the subjects consumed (39.47%), followed by magazines or pocket books (26.32%), radio (18.42%), newspapers (10.53%), and posters (5.26%).

Table 10 Number and percentage of top ten indicators used by HIV/AIDS patients to evaluate the efficacy of complementary and alternative therapies

Indicators	number	Percent
Less anxiety	84	41.4
Less fatigue	31	15.3
Better appetite	21	10.3
Less pain	20	9.8
More energy	11	5.4
Normal elimination	8	3.9
Less itching	7	3.4
Better breathing	5	2.5
Less frequent fever or URI	5	2.5
Good skin appearance	3	1.5
Less cough/secretion	3	1.5
Better sleep	3	1.5
Increased body weight	2	0.9
total	203	100

\*Note each patients might have used more than one sort of CAM to manage their health problem

#### Indicator to evaluate efficacy of complementary and alternative therapy

As shown in table 10, the indicator used to evaluate the efficacy of complementary and alternative therapy was symptom relief. The top five symptom reliefs were less anxiety (41.4%), followed by less fatigue (15.3%), good appetite (10.3%), less pain (9.8%), and more energy (5.4%).

### Perceived efficacy of complementary and alternative therapy used

Table 11 presents the score of perceived efficacy for each complementary and alternative therapy rated by the subjects.

Table 11 Frequency and scores of efficacy in relieving severity of symptoms of each sort of CAT\* as rated by HIV/AIDS patients

(Possible scores = 0-10)

Indicators of each sort of CAT*	Number	Actual score
<b>Pain</b>		
herb (local application)	3	8-10
exercise	3	8-9
nutritional supplement	1	8
yoga	3	7-8
reflexology	3	4-8
massage	4	3-8
concoction of herbs	1	10
total	18	
<b>Anxiety</b>		
massage	2	7-10
exercise	5	5-10
prayer	8	5-10
ritual ceremony	44	2-10
yoga	3	6
meditation	19	2-9
music	2	3-7
yore	1	2
steam room	1	2
aroma therapy	1	8
total	84	
<b>Fatigue</b>		
single herb	4	7-10
vitamin	2	7
nutritional supplement	7	1-8

CAT\* refer to complementary and alternative therapy

Table 11 (continued) Frequency and scores of efficacy in relieving severity of symptoms of each sort of CAT as rated by HIV/AIDS patients (possible scores = 0-10)

Indicators of each sorts of CAT*	Number	Actual score
concoction of herbs	2	4-7
exercise	16	3-9
total	31	
<b>Anorexia</b>		
nutritional supplement	3	8-9
concoction of herb	5	5-10
single herb	2	4-8
exercise	3	5-8
vitamin	8	4-8
total	21	
<b>Energetic</b>		
exercise	2	5-8
vitamin	3	4-8
nutritional supplement	6	5-10
total	11	

Note CAT\* refers to complementary and alternative therapy.

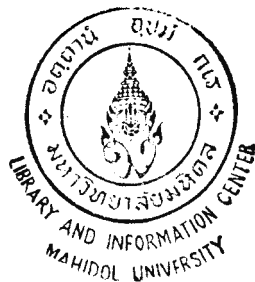
### Expenditure paid for complementary and alternative therapy

In table 12, monthly expenditure for each sort of complementary and alternative therapy was shown. The mean of monthly expenditure was between 22.50-1067.98 baht. The most expensive sort of complementary and alternative therapy was herb, followed by nutritional supplement, massage, and health food.

Table 12 Monthly expenditure of complementary and alternative therapies paid by HIV/AIDS patients

Sorts of CAT*	Number	Range	Mean	SD
herb	47	0-36,000	1067.98	5222.85
nutritional supplement	24	0-810	607.50	536.53
massage	8	50-1600	527.50	667.98
health food	3	0-500	316.67	275.38
reflexology	4	200-350	287.50	75.00
vitamin	17	30-1000	158.23	238.09
ritual ceremony	44	0-1000	141.82	184.31
aroma therapy	2	20-25	22.50	3.54

\*CAT refers to complementary and alternative therapy.



## CHAPTER V

### DISCUSSION

In this chapter, the findings of the study are presented and discussed.

#### **HIV/AIDS patients' demographic characteristics**

More than half of the subjects (59.1%) in this study were male, while 40.9% were female. Their age ranged from 21 to 60 years, with the mean age and standard deviation of 35.9 and 7.7 years, respectively. A total of 115 subjects were Buddhism. More than half of subjects were married (51.3%). The largest group of them had finished studying at the primary level (38.3%), were employees (44.3%), and had income between 4,001-8,000 baht per month (37.4%). The hometown of the 50 subjects (43.5%) was in the central region, and of the 36 subjects (31.3%) came from the northeastern region. However, overview of the demographic characteristics of this study was close to that of the previous studies in general such as age, occupation, and educational background. With regard to resources for hospital payment, the subjects received support from family, social insurance, and had reimbursement (18.3% each). Only 5 subjects (4.3%) were members of AIDS social network.

Close to half of the subjects in this study were in the symptomatic stage, followed by asymptomatic stage (31.3%), and full blown AIDS (21.7%). Most of them (64.3%) had been diagnosed with HIV infection for more than 1 year (mean = 3.2 years). Regarding the characteristics of the subjects, they tended to have a long

duration of time since diagnosis, and this might be due to the higher degree of effectiveness of conventional medicine to prevent or treat the opportunistic infections. Within a limitation due to economic problem, although the patients could not have 3 sorts of anti-HIV drugs, preventing opportunistic infection with primary or secondary prophylaxis can improve the patients' quality of life and prolong life expectancy (Thailand association of infectious disease, 2001:3). Of the 65 subjects (56.5%) who received anti-HIV drug, 79.1% had never been admitted in a hospital. Of 115 subjects, the largest group of subjects had no opportunistic infections (70.4%), while 9.6% were infected with tuberculosis, followed by herpes zoster (5.2%), and CMV retinitis and cryptococcal meningitis (4.3% each). Phuthong (2000:47-55) explored health status of 102 AIDS patients by comparing between patients with AIDS treated and not treated with AZT in Sakaew Crown Prince Hospital. This study found that the patients with AIDS treated had less opportunistic infection and had better health status than the others.

In this study, 99 subjects (86.1%) used complementary and alternative therapies combined with conventional medicine. In agreement with Chungsatiansap (1990:602), in reality, there is no one completed healthcare system which could treat every disease and satisfy the every dimension of patients' demands. This finding is consistent with the previous studies in which the results showed that more than 70% of HIV/AIDS patients used some sorts of complementary and alternative therapy (Dwyer, 1995:17-27; Knipple & Weiss, 2000:435 - 446; Sirisernwong,etal.;cited in Tantisak & permpornkul, 2000 : 20 ). However, this is in contrast to Muenhas & Pinitluek (abstract, 2001:344) who reported that 55.8% of HIV/AIDS patients used complementary and alternative therapy. This may be explained by various definitions

of complementary and alternative therapy in each study. Moreover, complementary and alternative therapy might change over time and be linked to other factors such as ethno-cultural background, gender, belief about health and illness, value and experience, information intake, socio-economic context, and conditions within each patient's life (Pawluch, et al., 2000: 251-264 ; Saengchat, 1997: abstract).

### **Sorts of complementary and alternative therapy**

Most of the subjects in this study 80.80% used more than one sort of complementary and alternative therapies combined with conventional medicine. Of these 30 (30.30%) used two sorts, followed by 29 (29.29%) who used three sorts, 19 (19.20%) who used one sort, 17 (17.17%) who used four sorts and 4 (4.04%) who used five sorts of complementary and alternative therapies. Using complementary and alternative therapy at least one sort in this study congruent with finding of previous studies (Dwyer, et al., 1995: 21; Singh, et al., 1996: 199; Ostrow, et al., 1997: 117 ; Fairfield, et al., 1998: 2257-2264; Knipple, & Weiss, 2000: 438 ).

A total of 99 cases, the largest group of complementary and alternative therapies, was mind-body control, followed by diet/nutrition/lifestyle change, herbs, manual healing, and energy therapy. The top five sorts of complementary and alternative therapies was herb, followed by ritual ceremony, exercise, avoiding taboo food, and nutritional supplement. This is consistent with Praves (1993:53) who pointed out that health depends on three relating factors in three dimensions i.e. biological dimension, psychological dimension, and social dimension. These three factors are interrelated. The strong feeling of being healthy will occur only when those three dimensions are in balance and harmony (Capra, 1996: 84). Thus, the

conventional medicine chiefly focuses on explaining particular system of organs under certain circumstance, while fails to describe the holistic and dynamic relation of the human body. This is because the biological dimension seems rather static but psychological and social dimensions rapidly change (Vasee, 1989: 2-8). Thus, attitude towards health without psychological and social dimensions cannot respond to the need of patients in all dimensions. Finding in the previous studies correspond with this view (Siegel, K. & Krauss, B.J., 1991: 17-32; Gaskin, S., & Brown, K., 1992: 111-121; Gloersen, B. et al., 1993: 44-58).

Sorts of complementary and alternative therapy used in this study are consistent with previous studies in Thailand which showed that health seeking behaviors are integrated, not only professional healthcare sector used by the patients but also including the popular and folk sectors (Saengchart, 1997: 42; Sirisernwong, et al; cited in Tantisak & Permpornkul, 2000: 20; Muenhas & Pinitluek, abstract, 2001: 344). The reasons for complementary and alternative therapy use are discussed in the next topic.

### **The reasons for complementary and alternative therapy used**

The most frequently reasons found for using complementary and alternative therapy could be categorized in to three main groups: symptom distress, suggestions from others, and promoting health. The results of this study reflect that to perform self-care behavior, there are many factors that influence the decision making process such as health status and information intake from various sources.

The results of this study show that symptom distress is the most frequently used reason to decide to perform complementary and alternative therapy (43.5%).

Wachtel, et al (1992) found that 90.2% of AIDS patients have symptom experience more than 4 symptoms such as fatigue, memory loss, sweating at night, dyspnea, chronic diarrhea, and uncontrolled weight loss. These symptoms affect their ability to perform functional ability, social functioning, mental health, and suffering from pain. This is consistent with the previous studies which found that symptoms i.e. fatigue, memory loss, and weight loss were related with complementary and alternative therapy use (Fairfield, et al., 1998: 2257-2264). Similarly, Ostrow, et al, (1997:115-119) which found that complementary and alternative therapy used by HIV/AIDS patients were used by the patients who suffered from pain due to disease progression.

Anxiety was the most frequently found symptom in this study. It may be explained by nature of the disease, which affects psychosocial well-being. Psychological impacts such as stigmatization, lifestyle changes, illness-related uncertainty, and existential issue related to diagnosis with a potentially fatal disease are the important factors, which affect the capability of patients to cope with the illness. Complementary and alternative therapy offers a person on coping with an illness a chance to feel better and healthier than do many conventional therapy. Some studies found that many individuals facing life-threatening diseases make decision to try alternative therapy as a way to regain some control over their health and their lives (Fryback, 1997: 64; Singh, et al., 1996:201).

In this study, itching was the second symptom related to complementary and alternative use. Similar to previous research conducted by Kutchamach (1997) at the same place, the subjects perceived high level of distress in shortness of breath, skin itching, and skin lesion. It may be explained that this symptom makes the patients have severe discomfort, while skin lesion creates stress as it shows status of HIV

infection to others especially in cases not ready to inform anyone about their diagnosis.

Pain, the third symptom related to complementary alternative therapy use in this study, is a common symptom among persons with HIV/AIDS. Pain may be related to complications of HIV infection (e.g., aphthous ulcer) or to the toxic effects of anti-HIV drugs (e.g., nucleoside analog-induced peripheral neuropathy). It is sometimes undertreated in persons with HIV/AIDS (Breitbart et al., 1997; Breitbart et al., 1996; Frich & Borgbjerg, 1996; LaRuet al, 1997; cited in Swanson, 2000: 44). The findings in this study are consistent with Ostrow, et al(1997:115-119) who stated that complementary and alternative therapy use in HIV/AIDS patients is found in patients who suffer from pain due to disease progression.

Suggestions from others was the second reason which the subjects in this study used in for deciding to use complementary and alternative therapy. Suggestions from others included family/relative, media consumed, friends, health personnel, etc. It will be discussed in detail under the next topic.

The third reason for using complementary and alternative therapy was promoting health. The most important self-care behaviors of HIV/AIDS patients in the researcher's view. It might be explained by the nature of the disease that it is a life threatening disease, which has, a rapid downhill course and no definite treatment, hence leading the patients to perceive high severity of illness. As a result, they struggle to maintain health. Corresponding to this view, the study found that the patients with HIV who used non-traditional therapy were actively trying to cope with the illness (Knipple & Weiss, 2000: 435). Previous research showed that maintaining health is one of the objectives to perform self-care behaviors (Siegel & Krauss, 1991:

17-32; Gaskin, & Brown, K., 1992: 111-121; Gloersen, et al.1993: 44-58; Nantachaipan, 1996: abstract; Wattradual, 1994 :abstract; Sangchart, 1997: abstract).

In spite of living with a fatal disease, a subject in this study described about a mean to maintain health:

*“I know that AIDS cannot be cured now. The way to help myself is to eat as much as I can. To promote my health status, I try to swallow food but it’s not easy for me. After I take vitamins, my appetite is better than before.”*

### **Sources leading the HIV/AIDS patients to use complementary and alternative therapy**

Symptom distress was the most important reason for using complementary and alternative therapy. Most of the original sources that led the patients to use complementary and alternative therapy to manage the symptoms were initiated by themselves (54.05%) and the influence of the information received from others (45.95%).

The most frequently found symptom in this study was anxiety. The sort of therapy initiated by the patients to manage anxiety was ritual ceremony i.e. giving alms to the monk, buying some kind of animal then getting them free, performing Sa-Dor-Kror ceremony to lessen misfortune (Thai word). Most of the subjects in this study said that they performed the ritual ceremony more frequently than before they were diagnosed with HIV/AIDS. Tansrirattanawong(1998: 96) studied spiritual healing in HIV patients and found that the most frequently performed activities of the patients were ritual ceremonies (97.5%). This showed that some sorts of complementary and alternative therapies could respond to spiritual needs of the

patients. The other symptom was skin itching; thus, self-care was performed by themselves because of discomfort, consistent with the previous studies ( Khumngern, 1999: 76; Kutchamach ,1997: 78) which found that skin itching was correlated with food or drug allergy, from their direct experience, leading to avoiding taboo food.

Of 48 cases who used complementary and alternative therapy to promote health, most of the original sources that led the patients to use complementary and alternative therapy to promote health were the influence of information that was received from others (64.6%) and their own initiation (35.4%). In this study, the only one sort of complementary and alternative therapy was initiated by themselves to promote health was exercise. Exercise is the pattern of self-cares behavior that is convenient to adapt to everyday life. Previous research stated that exercises benefit on psychological level and should be encouraged for HIV positive patients to promote the effectiveness of immune system (LaPerriere, 1997 cited in Greene, et al.,1999: 60).

As for suggestions from others, the most frequently sources used of information about complementary and alternative therapy of the subjects were family or relatives (27.2%), followed by media (23.4%), friends (17.9%), health personnel (13.6%), neighbors (7.4%), drugstores (6.8%), AIDS social network (3.1%), and from direct sales (0.6%). The result of this study is consistent with Kleinman's explanatory model (1980) which explains the influence of popular health care sector, in which illness is initially defined for an individual and treatment is initiated, containing many levels, including individual, family, social network, and community. The patients may use one or more of these levels for assistance during an illness episode to define symptoms, decide where to seek treatment, engage in

treatment, and evaluate treatment outcomes. Moreover the popular sector functions as the chief sources and most immediate determinant of care (Kleinman, 1980: 50). Previous studies also supported this view. For example, Samrongthong (1996: 121) surveyed the concept of explaining illness, personal behavior, and the search for treatment of 28 HIV/AIDS patients in a Buddhist monastery. The study showed that social network plays an important role in making decision on illness and treatment. In western research, the patients also learn about complementary and alternative therapy from family or friends, with a small percentage obtaining information from a physician or nurse (Drivdahl&Miser, 1998; cited in Braun, et al., 2000; 176-189). The finding of this study reveal that 22.22% of the sources of information were the health personal. Most of the information was suggestion to perform exercise and to opt for vitamin supplement.

Regarding media, television was the most frequently used media, consumed by the subjects (39.47%), followed by magazines or pocketbooks (26.32%), radio (18.42%), newspapers (10.53%), and posters (5.26%). Similarly Somboonburana (1999; 122) conducted a study on the factors leading to changes in personal healthcare behaviors by the principle of 'Cheewajit'. The finding showed that the supportive factors affecting the decision to change personal healthcare behavior can be divided into three aspects: information intake, recognition and realization of the importance of healthcare, and the convenience to comply with 'Cheewajit' principle and adapt to everyday life.

**Indicator to evaluate efficacy of complementary and alternative therapy**

Referring to the reasons the patients used to perform complementary and alternative therapy, this finding is not surprising because it depends on the reasons used to decide which symptom distresses were the central concern of the patients. The indicator used to evaluate the efficacy of complementary and alternative therapy in this study was symptom relief. The importance of symptom relief is that it helps the patients to maintain functional ability, a basic need of person, social function, health status, and well-being. So, symptom management is a significant point to improve upper level of functional ability without a support from others in HIV/AIDS patients (Leidy, 1994; cited in Kutchamach, 2540: 4).

According to Kleinman explanatory model which states that persons may use more than one healthcare system to handle illness problem, therapeutic response is one of the determinants for persons to use various forms of treatments (Kleinman, 1980: 194). This study shows that to combine western medicine with alternative medicine can better respond to the patients' need, resulting in a fulfillment of the holistic health of each patient better.

**Perceived efficacy of complementary and alternative therapy used**

Because of a very small sample size, this study could not explain the efficacy of complementary and alternative therapy in each modality. However, the trend of perceived efficacy's scores rated by HIV/AIDS patients in this research shows that complementary and alternative therapy could respond to the patients' need in the aspect of reducing symptom distresses. Previous studies surveyed complementary and alternative therapy in HIV/AIDS patients and found that overall improved quality

of life was found in 69% of the patients (Duggan, et al, 2001: 164). In the same study, regarding response to quality of life assessment among complementary and alternative therapy used, it was found that complementary and alternative therapy using helped HIV/AIDS patients to manage symptoms such as less pain (49%), less fatigue (55%), better sleep (52%), and less frequent fever or other infections (61%). Likewise, Astin (1998:115-119) found that relieving symptoms is the main benefit reported by people who used complementary and alternative therapy. The finding in this study came from the perception of the patients without the scientific method, but symptoms are personal experience. If the patients themselves feel they are better with the therapy, then they are.

As for pain relief as the aspect of perceived efficacy by the subjects in this study, some subjects described that Indian herbs helped them so much in a case of herpes zoster..

*“I could not sleep. I suffered a lot from pain around my trunk, so I did not hesitate when my neighbor told me about Indian herbs. I did not know how Indian herb affected my herpes zoster, but I felt its soothing and pain relieving effects.”*

*“Since I was sick from this disease (HIV), my menstruation was abnormal. I suffered from abdominal pain due to dysmenorrhea very much. I listened to a radio program about Thai traditional medicine to treat my symptom. I decided to have it. It worked. I can tell you its efficacy is 10 points or full score!”*

Using less fatigue as an indicator of perceived efficacy, some subjects described how exercise helped them:

*“Jogging helps me so much. It makes me less fatigued so I can go on my routine work effectively. I do not want to lose my job. I have to make myself normal, not different from others.”*

Less anxiety was another indicator cited by the subjects:

*“Praying Chin-Na-Bun-Chon makes me less nervous and I feel my life is better than before. I received Kum-Lung-Jai (Morale boost) from performing this activity.”*

*“Giving alms to the monk makes me less anxious. I try to do this every time I can. It makes me calm down and be in peace.”*

*“I learned about meditation when I was a monk. Nowadays, meditation still helps me when I feel anxious, especially in a crisis situation.”*

*“There are many things which make me concerned since I have been diagnosed with HIV. I have a lot of plans for my life, so I work harder than before. Massage helps me a lot for relaxation, both my physical and mental status.”*

An increase in appetite was cited as one benefit after performing exercise or having a concoction of herbs.

*“Jogging makes me hungry. I can eat a lot of food.”*

*“Having herbs makes me have a good appetite. I eat much more than before.”*

### **Expenditure for complementary and alternative therapy used**

The mean of monthly expenditure for complementary and alternative therapy was between 22.50 to 1067.98 baht. The most expensive sort of complementary and alternative therapy was herb, followed by nutritional supplement, and massage. Imaim & Puangsaijai (1999: 62) studied the expenditure of the patients living with

HIV/AIDS from the first diagnosis to death in a rural area in the north of Thailand and found that the expenditure per year for herb was 6,687 baht, 1764 baht for folk medicine, and 1696 baht for universal energy or meditation. Monthly expenditure for each sort of complementary and alternative therapy in this study seemed more expensive than those in the previous study. It might be explained that the previous study was conducted in the rural area, so the characteristics of the sample was different from those in this study, especially the socio-economic factors such as income. The range of expenditure for herbal use in this study is very wide because some patients received the herb from their social network. On the other hand, one of the subjects paid about 9,000 baht weekly for Chinese medicine, using the money that came from her savings and selling her treasure. In case of crystal therapy, the service is for free, but the patients pay about 4,500 baht for seven-colored stones. The others such as avoiding taboo food, universal therapy, and yore have no expenditures incurred.

However, the expenditures of the subjects might vary. The first reason is the variety of both types and amount of complementary and alternative therapy chosen. These varieties depend on the demand created by the impact of illness, which is differing in each patient's illness trajectory. The second is the frequency of the patients to get service i.e. massage, which is different in each person.

## CHAPTER VI

### CONCLUSION

This descriptive research aimed to explore complementary and alternative therapies use, the reasons which HIV/AIDS patients used in decision making about complementary and alternative therapy, the original source leading the patients to use each sort of complementary and alternative therapy, sources of information, expenditure paid for each complementary and alternative therapies, and perceived efficacy of HIV/AIDS patients when they used complementary and alternative therapies.

The target population of this study was HIV/AIDS patients from the Out-Patient Department of Medicine at Ramathibodi Hospital, from June to August, 2002. The subjects were selected by means of purposive sampling. The inclusion criteria were as follows:

1. Being 15 years of age or over;
2. Being diagnosed by the physicians to be infected with HIV and having been informed about the diagnostic result for at least 8 weeks, at any stage of the disease;
3. Having good consciousness and possessing speaking ability in Thai;
4. Being willing to participate in this study;
5. Going on foot to the Out-Patient Department of Medicine or being transferred by wheelchairs.

The interview forms used in this study were the semi-structured open-ended interview forms consisting of demographic data and the semi-structured open-ended questions related to sorts of complementary and alternative therapy which the subjects use, resource of information about complementary and alternative therapy, the reasons which the subjects used to use the therapy, indicators which the subjects used in evaluating the efficacy of complementary and alternative therapy, and the level of efficacy that they perceived. The researcher collected the data by interviewing. In this study, descriptions of the subjects are reported by using descriptive statistics: frequency, percentage, range, and mean. The conclusion of the findings are listed below:

1. Complementary and alternative therapies use in HIV/AIDS patients in this study were categorized into five groups: mind-body, diet/nutrition/lifestyle change, herbs, manual healing, and energy therapy. The most important group of complementary and alternative therapies being used by the patients was mind-body control, followed by diet/nutrition/lifestyle change, herb, manual healing, and energy therapy.

2. The reasons for performing complementary and alternative therapy were categorized into three main reasons i.e. symptom distress, suggestion from others, and promoting health. The results show that to perform self-care behavior, there were many factors influencing the decision making process such as health status and information intake.

3. In case of performing complementary and alternative therapy by the reason of symptom, most of the original sources that led the patients to perform complementary and alternative therapy to manage the symptoms were initiated by

themselves (54.05%), followed by the influence of the information received from others (45.95%). In case of using complementary and alternative therapy to promote health, the original sources that led the patients to perform complementary and alternative therapy were the influence of information that was received from others (64.6%) and their own initiation (35.4%). The only one sort of complementary and alternative therapy that was initiated by themselves to promote health was exercise. The most frequently sources of complementary and alternative therapy information were family or relatives (27.2%), followed by the media (23.4%), friends (17.9%), health personnel (13.6%), neighbors (7.4%), drugstores (6.8%), AIDS social network (3.1%), and direct sales (0.6%). As for media, television was the most important media which the subjects consumed.

4. Regarding the efficacy of complementary and alternative therapy, the indicator used in evaluating the efficacy of complementary and alternative therapy was symptom relief.

5. When dividing the data into a variety of modalities concerning the number of use of each sort of complementary and alternative therapy, the number was too small to explain the efficacy of each sort of complementary and alternative therapy. However, the overall perceived efficacy scores rated by HIV/AIDS patients in this research tended to show that complementary and alternative therapy could respond to the patients' need particularly to reduce symptom distress.

6. The mean of monthly expenditure for complementary and alternative therapy was between 22.50 to 1067.98 baht. The most expensive sort of complementary and alternative therapy was herb, followed by nutritional supplement and massage.

### **Limitations of this study**

1. Because this study did not obtain data about conventional medicine, the influence of them may affect the efficacy of complementary and alternative therapy.
2. Some patients may not tell the truth about the complementary and alternative therapy they used because they may be afraid that the doctor would know about their complementary and alternative therapy use.

### **Implications and Recommendations**

The findings from this study have provided considerations for nursing practice, education, and research as follows:

#### **Nursing Practice**

1. Nurses should obtain the data about complementary and alternative therapy used by the patients and experiences of symptom management in each patient in order to better assess and understand health seeking behaviors to reach the goal of holistic nursing care.
2. Nurses should keep up with knowledge in the area of complementary and alternative therapy including the efficacy of each sort of complementary and alternative therapy from evidence based practice.
3. Owing to the increasing public interest in complementary and alternative therapy, for their consulting role, nurses should be open-minded, accepting health seeking behavior of the patients, to enable patients to trust and facilitate nurses to explore their self-care behavior. Furthermore, knowing about the sorts of therapy that could be harmful to the patients is also necessary as nurses should design care plan most appropriate and safest for each patient.

4. The finding of this study showed that most of the patients got the information about complementary and alternative therapy from media such as TV programs, radio, and magazines, so nurses should give information about complementary and alternative therapy using these media.

### **Nursing education**

Due to the public interest in complementary and alternative therapy, it is imperative that nurses study about complementary and alternative therapy. Thus, the curriculum of nursing education should include a program for the young generation of nurses to learn about the various modalities of healthcare such as overview of complementary and alternative therapies or provision of the experience in this area with strong scientific base for them.

### **Future Research**

1. Because of the efficacy of each complementary and alternative therapy might be explained in more than one way, so it should be studied about effects of complementary and alternative therapy using on quality of life in this population.
2. Qualitative research should be carried out to more deeply understand about phenomena related to complementary and alternative therapy .
3. Perceived efficacy of complementary and alternative therapy, should be explore in the further research, particularly in the area of scientific method to get empirical data to effectively evaluate the efficacy of complementary and alternative therapy.
4. The effectiveness of each sort of complementary and alternative therapy for relieve symptoms should be examined and determine especially in full-blown AIDS population.

5. The present study was conducted in Ramathibodi Hospital, to gain various data about complementary and alternative therapy used by HIV/AIDS patients, further research should be conducted in other setting such as other types of hospitals, monasteries, or communities so that the findings could be generalized to a larger population.



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## APPENDIX A

แบบสัมภาษณ์ การใช้การรักษาแบบผสมผสานและการแพทย์ทางเลือก  
ในผู้ติดเชื้อเอช ไอ วีและผู้ป่วยเอดส์

ผู้ป่วยรายที่.....

HN.....

วัน เดือน ปี ที่สัมภาษณ์.....เวลา.....

ส่วนที่ 1 ข้อมูลส่วนบุคคล

1. เพศ .....1)ชาย .....2)หญิง
- 2.อายุ.....ปี
- 3.นับถือศาสนา .....1)พุทธ .....3)อิสลาม  
.....2)คริสต์ .....4)อื่นๆระบุ.....
- 4.สถานภาพสมรส  
.....1)โสด .....3)ม้าย  
.....2)คู่ .....4)หย่า , แยก
- 5.ระดับการศึกษา  
.....1) ไม่ได้รับการศึกษา .....4) ประกาศนียบัตรหรืออนุปริญญา  
.....2) ประถมศึกษา .....5) ปริญญาตรี  
.....3) มัธยมศึกษา .....6) สูงกว่าปริญญาตรี
- 6.อาชีพ  
.....1)ไม่ได้ประกอบอาชีพ .....5)ค้าขาย  
.....2)นักเรียน/นักศึกษา .....6)ธุรกิจส่วนตัว  
.....3)รับจ้าง .....7)รับราชการ/รัฐวิสาหกิจ  
.....4)เกษตรกร .....8)อื่นๆ ระบุ.....
- 7.รายได้เฉลี่ยต่อเดือน  
.....1)ไม่มีรายได้ .....5)12,001 – 16,000 บาท  
.....2)น้อยกว่า 4,000 บาท .....6)16,001 – 20,000 บาท  
.....3)4,001 – 8,000 บาท .....7)มากกว่า 20,000 บาท





ส่วนที่ 4 แนวคำถามในการสัมภาษณ์คำถามปลายเปิด

4.1 จากการใช้วิธีดูแลสุขภาพที่คุณบอกมา คุณมีเหตุผลอะไรหรือจะจึงเลือกใช้วิธีนี้

4.2 คุณทราบเกี่ยวกับวิธีดูแลรักษาสุขภาพที่ปฏิบัติอยู่จากแหล่งข้อมูลใด

- |         |                              |                            |
|---------|------------------------------|----------------------------|
| 1) สื่อ | ...1.1 หนังสือพิมพ์          | ...1.4 แผ่นป้าย / โปสเตอร์ |
|         | ...1.2 หนังสือ / พ็อกเก็ตบุค | ...1.5 วิทยุ               |
|         | ...1.3 โทรทัศน์              | ...1.6 อินเทอร์เน็ต        |
|         |                              | ...1.7 อื่นระบุ.....       |
- 2) ครอบครัว / ญาติ
- 3) เพื่อน / เพื่อนร่วมงาน
- 4) เพื่อนบ้าน
- 5) ศูนย์บริการให้คำปรึกษาทางโทรศัพท์
- 6) ชมรม / กลุ่มผู้ป่วยโรคเดียวกัน
- 7) หน่วยงานองค์กรเอกชนด้านเอดส์
- 8) บุคลากรสาธารณสุข ระบุ.....
- 9) อื่นๆ ระบุ.....

4.3 หลังจากปฏิบัติวิธีนี้แล้วอะไรจะทำให้คุณคิดว่าทำแล้วได้ผล

4.4 วิธีดูแลสุขภาพที่เล่ามาช่วยคุณได้มากน้อยแค่ไหนคะ ถ้าให้คะแนนโดย 0 หมายถึงวิธีนี้ไม่ได้ช่วยให้อะไรดีขึ้นเลย และ 10 หมายถึงวิธีนี้ช่วยคุณได้มากที่สุด คิดว่าคุณจะให้สักกี่คะแนนคะ

4.5 จากการดูแลสุขภาพด้วยวิธีนี้คุณต้องเสียค่าใช้จ่ายประมาณเดือนละเท่าไรคะ

## APPENDIX B

คำชี้แจงสำหรับผู้ป่วยและการพิทักษ์สิทธิของผู้ป่วยในการเข้าร่วมวิจัย

เรียน ผู้เข้าร่วมการวิจัยทุกท่าน

ดิฉัน นางสาวใจ ปิ่นตบแต่ง เป็นนักศึกษาปริญญาโทหลักสูตรพยาบาลศาสตรมหาบัณฑิต สาขาการพยาบาลผู้ใหญ่ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล สนใจที่จะศึกษาวิจัยเกี่ยวกับ การรักษาแบบผสมผสานในผู้ติดเชื้อเอช ไอ วี และผู้ป่วยเอดส์ เพื่อนำผลการวิจัยที่ได้มาใช้เป็นแนวทางในการพัฒนาองค์ความรู้และพัฒนาคุณภาพการพยาบาลสำหรับผู้ป่วยต่อไป จึงใคร่ขอความร่วมมือจากท่านในการให้การสัมภาษณ์ โดยในการสัมภาษณ์ข้อคำถามจะแบ่งออกเป็น 3 ส่วนคือ ข้อมูลพื้นฐานส่วนบุคคล ข้อมูลพื้นฐานด้านการเจ็บป่วย และประสบการณ์การรักษาแบบผสมผสาน โดยใช้เวลาสัมภาษณ์ประมาณ 30 นาที โดยในระหว่างการสัมภาษณ์นี้ดิฉันขออนุญาตอัดเทปเพื่อตรวจสอบความถูกต้องของข้อมูลในภายหลัง และจะไม่มีการกล่าวถึงชื่อของท่านในการสัมภาษณ์ คำตอบต่างๆของท่านทั้งหมดจะถูกเก็บไว้เป็นความลับ และนำมาใช้ตามวัตถุประสงค์ของงานวิจัยเท่านั้น

ท่านมีสิทธิจะตอบรับหรือปฏิเสธการเข้าร่วมการวิจัยครั้งนี้ และถึงแม้ท่านจะยินยอมเข้าร่วมการวิจัยแล้ว ท่านก็ยังมีสิทธิที่จะยกเลิกการเข้าร่วมการวิจัยได้ตลอดเวลาตามที่ท่านต้องการ โดยไม่มีผลต่อการตรวจรักษาหรือบริการที่ท่านได้รับ หากท่านมีข้อสงสัยประการใดเกี่ยวกับการวิจัยครั้งนี้ ดิฉันยินดีจะตอบให้ท่านเข้าใจตลอดเวลา

ขอขอบคุณในความร่วมมือของท่าน

สายใจ ปิ่นตบแต่ง



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