

MAKING THE CHOICE TO USE HERBS:
PATHWAYS TO THE PRACTICE OF HERBALISM

BY

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MAKING THE CHOICE TO USE HERBS:
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Abstract

This study examines how herbal medicine users chose to begin using herbal medicine: How do people learn about, become interested in, and begin using herbal medicine? How do social, cultural, personal, and situational factors uniquely combine in temporally experienced sequences and in varying degrees of influence upon users' choice to begin using herbal medicine? I thematically analyzed data from 28 intensive face-to-face interviews with current medicinal plant users in Cincinnati, Ohio and St. Louis, Missouri and recorded observations of herbal medicine use in written field notes and photographs. I found that participants tread one of three different paths in the process of choosing to use herbal medicine. A quarter of participants began using herbal medicine out of a general interest in its use cultivated by social and cultural influences and experiences with herbal medicine throughout the life course. Nearly half of participants began their path with an interest in herbal medicine that that led them to use herbal medicine in response to a situational condition in tandem with the belief that herbal medicine was safer, more accessible, or a better fit than Western medicine. Over a quarter of participants began using herbal medicine after becoming ill or injured and determining that Western medicine was less safe, less effective, or less accessible than herbal medicine. Nearly all participants indicated varying degrees and different forms of concern about pharmaceutical medicine. Most participants indicated a desire to use herbal medicine before seeking Western medical attention, but acknowledged that Western medicine was preferable in certain circumstances, such as to treat traumatic injuries, sudden illness, and chronic pain. The findings of this research complement and expand the growing body of research on the use of complementary and alternative medicine (CAM) in the Sociology of CAM with a qualitative analysis of how current medicinal plant users initially began using herbal medicine.

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Chapter 1: Introduction and Review of Research

INTRODUCTION

Plants were the primary source of medicine in colonial America until the 1800s when Western medicine emerged and dominated the plurality of medical practices available (Griggs 1997; Starr 1982). Despite dormancy in Americans' use of plants for medicine in following decades, public interest in the use of plant-based medicine grew in the 1960-70s and the 1990-2000s: Eisenberg et al. (1998) found that the use of herbal medicine increased from 2.5% of the American adult population in 1990 to 12.2% in 1997. By 2002, 18.9% of the American adult population indicated past year use of herbal medicine (Bardia et al. 2007). This research seeks to understand why and how American adults are increasingly turning back to the use of plants for medicine.

Government and academic researchers often refer to the use of plants for medicine alongside other traditional medical therapies under the umbrella term, complementary and alternative medicine (CAM). CAM therapies are becoming increasingly popular in developed nations, with over 50% of the population of Europe and North America indicating lifetime use of a CAM therapy (World Health Organization 2003). Herbalism is commonly referred to as the use of plants for medicine and, in practice, varies based on cultural traditions and geographic plant availability. For example, Traditional Chinese Medicine (TCM) is primarily based on plant medicine and used by over 50% of the Chinese population. Another example is Ayurveda, primarily practiced in India, which includes diet and plant remedies (International Agency for Research on Cancer 2002). In America, Canada, Europe, and Australia, the primary form of herbalism practiced is Western Herbal Medicine (WHM), distinguished by its roots in the use of European native plants in accordance with European traditions, as well as influence from TCM,

Ayurveda, and, in America, Native American and Wise Woman traditions (Bitcon et al. 2016; Dougherty 2004; Nissen and Evans 2012).

The professional practice of herbalism in America is limited by medical practitioner licensing laws and Federal Drug Administration (FDA) regulations that disallow herbalists and herbal product manufacturers to diagnose, prescribe, or claim to treat or cure illness; and there is little reliable scientific information available to guide the safe and effective use of herbal medicine (Bent 2008; Winnick 2005). Ascertaining the efficacy of herbal medicine in scientific research is fraught with difficulty and constitutes an obstacle to fully integrating herbalism with Western medicine in integrative medical practices in Europe and Australia, where Western medical ontologies, epistemologies, and medical practices continue to dominate, rather than to integrate, the practice of herbal medicine (Broom and Adams 2009; Mizrachi, Shuval, and Gross 2005; Owens 2015; Polich, Dole, and Kaptchuk 2010).

Academic research proliferated throughout the 2000s in an attempt to explain why people were increasingly turning to CAM. Their focus was on structural reasons for CAM's growing popularity (e.g., changes in the structure of medicine, economy, and politics) and socio-cultural and individual reasons for using CAM (e.g., dissatisfaction with Western medicine, a change in cultural values, and the influence of social movements) (e.g., see Coulter and Willis 2004; Goldstein 2002). Little research focused primarily on the conditions prompting herbal medicine use, particularly in the US, and less sought to explain how medical experiences and individual, cultural, and social factors coalesced in varying combinations and degrees of influence upon a person's choice to begin using herbal medicine. Even less research addressed the temporal ordering of these influences upon a person's choice to begin using herbal medicine.

Understanding the initial process that herbal medicine users engaged in when beginning to use herbal medicine will contribute to the small, but growing, body of research in the Sociology of CAM by adding a qualitative analysis of the process by which people make the choice to use herbal medicine beyond the boundaries of the dominant Western medical paradigm in America. In particular, understanding how people make the choice to use herbal medicine can uncover the process by which people begin using a specific CAM therapy, as well as how people learn to use herbal medicine despite the marginalization of the professional practice of herbalism and little accessible scientific research guiding the use of plant medicine in America.

This research seeks to answer the question, Why and how are American adults turning back to plants for medicine? More specifically, how does one initially make the choice to use herbal medicine: How do medicinal plant users learn about, become interested in, and actually begin using herbal medicine? How do social, cultural, personal, and situational factors uniquely combine in varying degrees of influence upon a person's choice to begin using herbal medicine? In what sequences do people experience influences upon their choice to use herbal medicine?

I begin with a brief history of American medicine with a focus on the emergence of Western medicine and its dominance over the practice of herbal medicine. This is essential to understanding why people's historical use of plants for medicine declined in 19-20th century America and how these conditions provide a baseline for understanding the increased popularity and use of medicinal plants in recent decades. Next, I discuss structural factors leading to the growing popularity, as well as the continued marginalization, of American herbalism from the 1990s to present in order to provide the structural context for the increasing rate of herbal medicine use in the US. This is followed by a review of research indicating the extent of CAM use among American adults and particular user sub-groups and the reasons indicated for

individuals' use of CAM, research that specifically addresses medicinal plant and herbal product use, as well as work from the Sociology of Health and Illness and its "poor cousin," the Sociology of CAM (see Bilson and Lee-Treweek 2006). This chapter concludes by returning to the research questions prompting this study and their significance for the Sociology of CAM.

HISTORICAL BACKGROUND

A critical sociological approach to health practices entails focusing on the importance of a deeper understanding of health activities that emphasizes the historical and macro-level dynamics of power and the strategies employed to establish and reproduce epistemic authority (Adams et al. 2009a). The history of American medicine is fraught with conflict between Western medicine and herbal medicine. In America's earliest days, plants were the primary source of medicine, practiced by Native Americans, women healers, mid-wives, and predominately white male medical doctors (Griggs 1997; Starr 1982). Native American Traditional Medicine was largely suppressed in the mid-19th century as public officials deemed Western medicine an instrument of assimilation (Reifel 1999). As the medical profession emerged and grew throughout the 18-19th centuries in America, and in tandem with the gender roles of that time, women's knowledge of medicinal plants, known today as the Wise Woman tradition, was devalued and their practice of medicine and assistance with child birth deemed unfit for women (Tilly 1999; Wertz and Wertz 2012). During the 1800s, professional medicine was characterized by a plurality of medical sects, all primarily comprised of white males. Many sects¹ incorporated plants in their repertoire

¹ Homeopathy stems from the principle of 'like curing like,' such as by using small doses of plants and mineral preparations to cure ailments that would, in larger doses, insight the same ailment. In contrast, botanic doctors relied primarily on plants for medicine to support, nourish, and heal body and mind. In the early 1800s, botanics divided into different medical sects, including the Thomsonians and the eclecticists (Berman and Flannery 2000). In contrast to Thomsonians who, in addition to using plants for medicine, incorporated purgative processes such as sweating and vomiting, eclecticists maintained a primary focus on the more gentle use of plants for medicine. Allopathic doctors differed from homeopaths in their belief that the remedies for an ailment were different than

of medicine and healing modalities. At the same time, another medical sect emerged in the tradition of European professional medicine, termed allopathy (Haller 2005).

Marginalization of Herbalism

Allopathy's rise to medical dominance laid in its claim to medical knowledge based on "scientific" and "technological advances" as it simultaneously discredited other medical sects. Shortly after the American Medical Association was established by allopathic physicians in 1847, their code of ethics was revised to exclude other medical sects (Ruggie 2005; Starr 1982). Decades of discursive conflict ensued as the American Medical Association (AMA) labeled the eclectics, homeopaths, and other medical sectarians as quacks and irregulars while labeling itself as regular medicine (Winnick 2005). Looking back, this propaganda campaign was characterized in 1968 by the President of the AMA as having cost the organization more than the cost of all prior medical education and research in America (Craft 2014; Jones 2004; Ruggie 2004). As a result, Americans came to see that "reformed, sectarian, cultist, and irregular were terms that really implied substandard quality, misplaced objectives, and idiosyncratic reasoning" (Haller 1994:227).

Allopathic medicine increasingly dominated American medicine. The percentage of medicinal substances deemed botanically-derived dropped from 54% in 1900 to 44% in 1920, a mere decade after the AMA inspected medical schools nationwide and assigned failing grades to the vast majority of sectarian medical schools in the 1910 Flexner Report (Boyle 1990; Griggs 1997; Haller 2005; Ruggie 2004; Weiss and Miller 2010). In tandem with medical school inspections and the Flexner Report, the AMA imposed its political influence to define American medicine

those that might incite the ailment. Early allopathic doctors incorporated bleeding, blood-letting, mercury/calomel, and other purgative processes in addition to the use of plants and synthetic compounds.

through the construction of state licensing boards that would only confer the title of a doctor to those who had graduated from AMA approved medical colleges, which by 1923, included only two homeopathic and one eclectic school (Griggs 1997; Haller 1994, 2005; Ruggie 2004). Shortly after the AMA's official exclusion of sectarian schools in 1938, the last eclectic medical school, the Eclectic Medical College in Cincinnati, Ohio, closed its doors after over 100 years of steadfast adherence to beliefs that form the core of American herbalism today: vitalism, holism,² and the use of whole plant medicine (Haller 1994).

Allopathy achieved domination in American medicine during the 20th century by way of a “legally enforced monopoly of practice” (Conrad and Schneider 2012:220; see also Griggs 1997; Starr 1982; Winnick 2005). At the same time, popular knowledge of plants transitioned to a ‘dormant ethnobotany,’ whereby knowledge of how to use herbal medicine became inactive, but survived in memory, historical records, and folklore (Leopold 2011). Despite the “herbal suppression” of the 1950s-1970s, people’s interest in the use of plants for medicine grew in tandem with growing public disenchantment with adverse health effects resulting from some of Western medicine’s advances (e.g., the Thalidomide tragedy) and an affinity for the emergent 1960s back-to-nature movement (Griggs 1997; Winnick 2005). The extent to which the historical reliance on and political suppression of herbal medicine use informs modern day herbal medicine use is to date an under-researched topic that this research aims to shed light on.

The Herbal Resurgence

Knowledge about the use of herbal medicine became more widely available throughout the 1960s-1990s (Griggs 1997). The 1994 passage of the Dietary Supplement Health and Education

² In short, vitalism refers to the healing power of nature and holism refers to the whole being greater than its parts (Coulter and Willis 2004; Evans 2008).

Act (DSHEA) classified medicinal plants as dietary supplements that can be bought and sold without FDA approval, thus mitigating the need for herbal product manufacturers to demonstrate proof of the plant's medicinal efficacy or safety. While this reassessment of laws overseeing the herbal product market allowed manufacturers to produce and sell their herbal products without scientific proof of their safety and efficacy, it simultaneously disallowed herbal product manufacturers from making any claims about the safety and efficacy of plant medicine. According to law, herbal product manufacturers and herbalists cannot “diagnose, cure, mitigate, treat, or prevent illness” (Bent 2008:855). In order for manufacturers to claim that a plant will have any effect on human bodies, they must also include a disclaimer on their products' labels.³ To avoid FDA charges of health fraud while still indicating what an herbal product may be used for, herbal manufacturers and practitioners engage in what Angell and Kassirer (1998, c.f. Winnick 2005:52) characterize as “an art form of doublespeak.” In effect, herbal product consumers are left with little-to-no indication of how to use the product and no assurance that the herbal product is either safe or effective. Those who wish to begin using herbal medicine must seek information about its use from other knowledge sources.

Despite these barriers to the use of herbal medicine, there is an emergent movement in the United States, Europe, and Australia to integrate CAM therapies into Western medicine. In the US, the National Institute of Health created and funded the Office of Alternative Medicine in 1992, later renamed the National Center for Complementary and Alternative Medicine (NCCAM), and ultimately renamed again in 2014 as the National Center for Complementary and Integrative Health (NCCIH). The mission of NCCIH is to “define, through rigorous scientific investigation, the usefulness and safety of complementary and integrative health interventions

³ i.e., “This statement has not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevent any disease.”

and their roles in improving health and health care,” with an objective to “develop and disseminate objective, evidence-based information on complementary and integrative health interventions” (NCCIH 2015a).

The question of what constitutes objective evidence of the medical efficacy of plants, however, remains. Evidence-based medicine (EBM), as classically defined by Sacket et al. (1996), means integrating clinical expertise and high quality research evidence in research evaluating the efficacy of medical treatments (also see Jagtenberg et.al. 2006: 324). In practice, EBM emphasizes the control of effects like subjectivity, therapeutic setting, and the personality of the therapist from the etiology and experience of illness (Adams et al. 2002). EBM is an ideal type for ascertaining evidence of medical efficacy; EBM assumes standardization in the patient, therapist, ailment, and treatment (Adams 2002; Barry 2006; Evans 2008).

Many scholars counter the notion that EBM is compatible with the epistemology underlying CAM practices. In contrast to Western medicine, the practice of herbal medicine is based in the beliefs of vitalism and holism, whereby vitalism is the vital force that allows the body to heal, a sum of interactions among the healing energies of the patient, therapist, treatment, and setting; and holism refers to the inseparability of mind, body, spirit, and environment in health and illness (Evans 2008; Hirschhorn 2006). The practice of herbalism entails an evaluation of the individual patient, including their physical, mental, and spiritual status, and takes into account the complexity of individual interactions with the practitioner, social settings, and treatment regimens (Adams 2002; Barry 2006; Barsh 1997; Derkatch 2008; Evans 2008). In short, the practice of herbalism, alongside many other CAM therapies, is not easily standardized or controlled.

A determination may be made between scientific, biomedically-ascertained, efficacy (i.e., “what a treatment can do under ideal circumstances”) and personal, socially-derived notions of effectiveness (i.e., “what a treatment does do in routine daily use”) (See Committee on the Use of Complementary and Alternative Medicine by the American Public 2005, c.f. Derkatch 2008:382). Critics maintain that EBM may be best suited to provide evidence for the *efficacy* of standardized herbal products for herbal product consumers, manufacturers, and practitioners. However, EBM is an ill-fitting construct for the *effective* use of plants for medicine in the everyday lives of many users and practitioners who grow, harvest, and process their own plant materials; individually tailor plant medicine preparations and treatment regimens; and who incorporate other dietary and lifestyle changes.

This distinction reflects the bifurcation of WHM today into traditional herbalism and scientific herbalism, whereby the former retains traditional epistemologies underlying the traditional use of plant medicine and the latter accepts the ‘scientization’ of herbalism (Evans 2008; Singer and Fisher 2007). As with all ideal types, there are many herbalists and herb users who incorporate elements of both to varying degrees (Dougherty 2004). In defense of scientific herbalism, Wahlberg (2008) counters the notion of co-optation with the assertion that the plethora of work on the biomedical colonization of herbal knowledge is an “oversimplification at best,” as it fails to account for the “complex interactions and co-circulations of concepts and practices that constitute the microphysics of herbal medicinal product development” (p. 3). In this view, the standardization of medicinal plants into pill-form herbal products is no more than the normalization of herbalism in the effort to give plausibility to their mechanisms of action and efficacy. Nonetheless, conflicts abound with regard to the ontology and epistemology underlying what is effective medicine in America, conflicts that may be understood further by

examining how herbal medicine users experience and navigate WHM and Western medicine boundaries and constructs when beginning to use herbal medicine.

Conflicts surrounding the debate between integration and co-optation, and scientific and traditional herbalism led Winnick to assert that sociologists “will continue to enjoy this unique opportunity to observe first-hand the “regulars” and “irregulars” entangled in conflict yet again, just as they were a century ago” (2005:57). There is a growing body of research, mostly in Canada, Europe, and Australia, that seeks to understand the extent of integration and co-optation of CAM in integrative medicine settings, much of which documents the continued dominance of Western medicine ontologies, epistemologies, and therapies in integrative settings (e.g., Broom and Adams 2009; Hollenberg 2006; Mizrachi, Shuval, and Gross 2005; Owens 2015; Polich, Dole, and Kaptchuk 2010). It is yet unknown, however, how porous and open the professional boundaries surrounding Western medicine will become in the move to integrate CAM in American medicine. Understanding how herbal medicine users navigate the boundaries of Western medicine can inform WHM and Western medicine reform in the move towards integrative medicine.

A challenge facing social scientists studying the use of CAM lies in understanding how people make a choice to begin using CAM (Baer and Coulter 2008). This research seeks to understand whether people use medicinal plants as an alternative to Western medicine, to complement Western medicine, or do people seek to integrate aspects of both medicine systems in their health regimen? In an era of Western Medical dominance, why are people increasingly turning to the use of plants as medicine? Further, as the practice of herbalism relies more on everyday knowledge, or knowledge that is accessible to the public and professionals alike, than on expert knowledge generated by Western medicine (see Hirschorn 2006); and given the historical

suppression of medicinal plant knowledge, the lack of use indications on herbal products, and little reliable evidence-based research on the safety and efficacy of herbs and herbal products, the question arises: How do people learn to use plants for medicine?

REVIEW OF RECENT RESEARCH: HOW AND WHY PEOPLE USE CAM

Distinguishing Between CAM and Herbal Medicine

Sociologists have focused their research on patterns of CAM use and factors motivating CAM use across different demographic populations and sub-groups, with attention paid to health status, beliefs and values, and the influence of social networks and social movements. In the following section, I draw upon work in Medical Sociology, the Sociology of Health and Illness, the Sociology of CAM, and other relevant research to explain why and how someone turns to CAM and, where information is available, herbal medicine. But first, how are dietary supplements, non-vitamin non-mineral (NVNM) supplements, and herbs distinguished?

The majority of research into the rate of CAM use, the population of users, and reasons for its use focus on CAM in general. It is less common to distinguish dietary supplements from other CAM modalities, where a dietary supplement is a product that contains one or more dietary ingredients, is intended to be orally ingested, and is labeled as a dietary supplement (NCCIH 2015b). While important to further distinguish among different categories of dietary supplements in order to understand why someone may use a particular type of dietary supplement, it is rare for research to distinguish between vitamins and minerals, NVNM supplements, natural products, and herbs, where:

- Natural products include extracts and other substances produced by marine organisms, bacteria, fungi, and plants, which includes things like herbs, vitamins, minerals, and probiotics (NCCIH 2015d).
- NVNM supplements are natural products with the exclusion of vitamins and minerals, and include things like herbs, fish oil, glucosamine, probiotics, melatonin, and amino acids in addition to herbs.
- Herbs refer to crude plant material, which may be used in a whole state, fragmented, or powdered. A finished herbal product may include juices, oils, vinegars, water, honey, alcohol, and other materials used in processing the plant material (World Health Organization n.d.). In this research, I use herbs, herbal medicine, and medicinal plants interchangeably.

As much of the research on the increase in use of medicinal plants is steeped in discussions surrounding the growth of CAM and subsumed in categories that include other dietary and NVNM supplements, the following will discuss factors relating to the growth of CAM with an emphasis on specific data regarding NVNM supplements, natural products, and herbs where available.

Extent of CAM and Herbal Medicine Use

Despite the continued marginalization, co-optation, and move to integrate CAM practices in Western medicine, the use of CAM and herbal medicine continued to gain popularity throughout the 1990s to the present. There are two large national surveys that measure the extent of dietary supplement use by American adults: the National Health and Nutrition Examination Survey (NHANES), which began surveying American adults' use of dietary supplements in 1988; and

the National Health Interview Survey (NHIS), which began querying the use of NVNM supplements in 2000. From 1990 to 2007, the use of CAM in general, including the use of NVNM supplements, grew, though a slight decrease in use was found in 2012 NHIS data. According to NHIS data, 32.3% of American adults indicated the use of CAM in 2002, increasing to 35.5% in 2007, and decreasing to 33.2% in 2012 (NCCIH 2015e). The most popular CAM therapy is the use of dietary supplements. According to NHANES data, over 40% of American adults used dietary supplements in 1988-1994, increasing to over 50% in 2003-2006, with multivitamins and multi-minerals being the most commonly used dietary supplement (National Center for Health Statistics 2011). In terms of NVNM dietary supplement use measured by the NHIS survey, 14.5% of adults indicated past year use of NVNM supplements in 2000, increasing to 17.7% in 2007, and remaining more or less steady at 17.9% in 2012 (Barnes, Bloom, and Nahin 2008; Millen, Dodd, and Subar 2004; Wu et al. 2014).

When it comes to the use of herbs in particular, Eisenberg et al. (1998) initiated a telephone survey of over 1500 American adults in 1991, and another 2000 adults in 1997, and found that past year use of herbal medicine increased from 2.5% of the adult population in 1990 to 12.1% in 1997. In 2002, the NHIS included an Alternative Medicine supplemental questionnaire that specified herb use, and found that 18.9% of American adults indicated past year use of herbs (Bardia et al. 2007). Parallel increases in CAM and herb use are also documented in Britain and other European countries, Canada, and Australia (Coulter and Willis 2007). In addition to nationwide herbal use data, there are many surveys designed to capture NVNM and herbal supplement use within specific populations, including varying demographic groups and people with specific health conditions.

Demographic Correlates

Regionally, Peregoy et al. (2014) found that adult use of NVNM dietary supplements was highest in the Mountain region of the United States (28.7%), followed by the Pacific (23.3%) and West North Central region (23.1%); while the Middle Atlantic (13.6%), West South Central (13.6%) and South Atlantic (13.1%) had the lowest rates of NVNM dietary supplement use.

Geographical dietary supplement, NVNM supplement, and herb use data remains roughly steady when compared to other use studies with higher rates indicated in the west and north and lower rates indicated in southern and eastern regions of the US (e.g., Barnes, Bloom, and Nahin 2007; Gardiner et al. 2007; Kennedy 2005; Rozga et al. 2013).

In an analysis of the 2012 National Health Interview Survey data, Wu et al. (2014) found that 19.2% of women and 16.4% of men used herbs and dietary supplements in the past year, with the percentage of female users decreasing from 21% in 2002. Other NVNM dietary supplement and herb use research confirms that rates of herbal medicine use are higher among women than men (see Bardia et al. 2007; Barnes, Bloom, and Nahin 2008; Eisenberg 1998; Gardiner et al. 2007; Hall 2007; Kennedy 2005). While in 2002, 20% of adults aged 18-64 used herbs and dietary supplements compared to 13.2% of those aged 65+, use among those over 65 years of age increased to 18.2% in 2012, surpassing younger adults' use (Wu et al. 2014). As education and income increase to above 12 years of education and over \$35,000 in yearly household income, so too does herb and dietary supplement use (Bardia et al. 2007; Barnes, Bloom, and Nahin 2008; Gardiner et al. 2007; Wu et al. 2014).

With regard to race and ethnicity, Wu et al. (2014) found lower rates of herb and dietary supplement use among non-white (12.9%) and Hispanic populations (11.3%) than among the

white, non-Hispanic population (19%). In contrast, Gardiner et al. (2013) found higher average use rates among African Americans (17%; with a range from 1-46%), Asians (30%; with a range from 2-73%), and Hispanics (30%; with a range of 4-100%) in their review of over 100 research studies on herb use by racial/ethnic minorities. In Gardiner et al.'s (2013) review, the size and geographic location of the studies' samples had a significant effect on the rate of herb use among these populations. Reporting racial and other sub-group discrimination, in both medical and non-medical settings, is correlated with greater use of CAM (Pawluch, Cain, and Gillett 2000; Shippee, Schafer, and Ferraro 2012). And, while recent immigrants have lower rates of CAM use compared to the larger American adult population, their use rate approaches nationwide adult use the longer they reside in the country (Su, Li, and Pgan 2008).

Studies on US college students indicate a greater prevalence of NVNM and herbal use than nationwide adult use data. The percent of college students who used a NVNM supplement in the past year range from 79% of students surveyed at an unnamed large state university (Johnson and Blanchard 2006), to 54% of undergraduates surveyed at a midsize Midwestern university (LaCaille and Kuvaas 2010), and 26.3% of surveyed students at an urban, mid-sized university (Perkin et al. 2002). When it comes specifically to the use of herbs, 51% of surveyed Rutgers University students indicated past year use (Ambrose and Samuels 2004), 48.5% of surveyed Washington State University students (Newberry et al. 2001), and 23.7% of students at the University of Kansas, Lawrence and Haskell Nations Indian University (Craft et al. 2015).

Health Status

Research has additionally confirmed that CAM and dietary supplement use rates are higher than those reported in the larger adult population for pregnant women, cancer patients, HIV/AIDS

patients, people with cognitive disorders, and people with anxiety. Branum, Bailey, and Singer (2013) found that 77% of pregnant American women indicated overall dietary supplement use, with the vast majority indicating use of multivitamins/multi-minerals, folic acid, and iron. This finding reflects prenatal practitioners' standard recommendations to take folic acid and multivitamins and to strictly limit the use of pharmaceuticals during pregnancy. Kennedy et al. (2013) found that 29% of pregnant women in the US used herbs, with much higher use rates indicated in Russia (69%), Eastern Europe (51.8%) and Australia (43.8%). Mao et al. (2010) found that 26% of cancer patients surveyed in the 2007 NHIS survey indicated past year use of biologically-based therapies (comprised of herb use and special diets). Research in Europe and Australia additionally indicate high use rates of CAM among cancer populations (e.g., see Molassiotis et al. 2005; Yates et al. 2005). Use of CAM among HIV/AIDS patients is also high, with 2/3 of American study participants indicating CAM use in Foote-Ardah's (2003) research and 42% of study participants in Anderson et al. (1993). Laditka et al. (2012) found that adults reporting cognitive problems were more likely to use dietary supplements than other 2007 NHIS respondents. In a review of research investigating herbal use for anxiety, McIntyre et al. (2015) found higher herb use rates among anxiety sufferers compared to the larger US population.

Yet, the majority of herb use is intended for nourishment and general wellness rather than to treat a particular ailment. According to NCCIH (2015e), over 85% of NVNM dietary supplement users do so for wellness rather than to treat a specific health condition. In particular, surveys indicate that people use herbs to improve their health status, to supplement a poor diet or unhealthy lifestyle, to relieve symptoms associated with chronic illness, and to prevent chronic disease (Barnes, Bloom and Nahin 2007; Egan et al. 2011; Kennedy 2005). While there are a few studies that examines how specific health needs may lead one to use CAM (e.g., Foote-

Ardah 2003; Mitchell and McClean 2014; Pawluch et al. 2000; Yates et al. 1993); to date there is no research focusing on the immediate, lived experience of health needs prompting people to initiate the use of herbal medicine.

Cultivation of Knowledge

When it comes to the specific use of herbs for health and well-being, the most commonly cited sources of information are friends and family, followed by media and health food stores (Ambrose and Samuels 2004; Perkin et al. 2002; Kuo et al. 2004; Lohse, Stotts, and Priebe 2006). In one of few studies designed to qualitatively explore how factors combine and contribute to people's choice to use CAM, Caspi, Koithan, and Criddle (2004) concluded that "...different patients may appreciate different forms of information when making decision regarding their health. In addition, these differences in decision paths may explain why some patients are more likely to use CAM" (pp. 76-77). Little is known about the process that herb users engage in when they begin using herbs, such as the conditions under which medicinal plant knowledge was offered, why people listened and acted upon that knowledge, what factors and conditions prompted people to seek knowledge, or how people go about finding information. While this large body of research addresses some demographics, medical ailments, and knowledge sources correlating with the use of CAM and medicinal plants, the question remains, why are American adults increasingly turning to the use of plants for medicine? What recent social structural changes, and what other social, cultural, and personal factors influence one to use CAM?

Structural Influences

From a macro-sociological standpoint, the growing popularity of CAM and herb use reflects changes in social structures, including a growing CAM industry, greater political acceptance of CAM, and changes in the structure of Western medicine (Bardia et al. 2007; Coulter and Willis 2004; Gale 2014; Goldstein 2002; Ruggie 2004). Economically, herb retail sales in the United States steadily increased from roughly \$4.1 billion in 2003 to \$6.4 billion in 2014 (Smith et al. 2015). Dietary supplements are increasingly available on-line and in places like local grocers, pharmacies, and warehouse stores; and advertising of herbal products is more widespread (Bardia et al. 2007; Goldstein 2002). Politically, the US government has continued funding for NCCIH research on CAM and continually considers FDA legislation on dietary supplements; and CAM providers are increasingly professionalizing and becoming licensed, leading to greater medical insurance coverage and general social acceptance of CAM (Goldstein 2002). As economic and political structures increasingly accept CAM, social awareness and use of these medical modalities grow in tandem with them and the burgeoning plethora of readily available information on-line (Barnes et al. 2004; Goldstein 2002).

Public trust in Western medicine

At the same time, the structure of Western medicine in America has changed in recent decades. McKinlay and Marceau (2012) document numerous factors that accompanied the transition from US healthcare as a fee-for-service industry controlled by professionals to a corporatized system dominated by increasingly concentrated and globalized financial and industrial interests. This transition resulted in less partisan support for health care in tandem with increasing industrial and financial interest in the medical market and the increasing bureaucratization of healthcare

characterized by streamlined doctor visits, diagnoses, and treatments. A growing reserve of doctors and other specialized health care workers, combined with a decline in centralized doctors' unions and organizations, contributes to intra- and interdisciplinary conflict, weakens market production via an oversupply of health care professionals, and makes for a less unified medical profession to exert political influence. A concomitant increase in medical information available to the public led to a more empowered and engaged public. And, Western medicine must account for recent changes in disease epidemiology, characterized by an increase in degenerative, chronic, and human-made diseases, itself partly an effect of changing demographics and globalization patterns (see also Rosich and Hankin 2010; Timmermans and Oh 2010).

These changes alongside the growth and influence of the pharmaceutical industry contribute to a steady decline in patient trust in Western medicine. Since the 1960s, public trust in confidence in medicine, alongside other institutions (e.g., education, Congress, military, religion, mass media) has declined in all major demographic groups (Norris 2002). While in 1966, 73% of the American public expressed confidence in medicine, by 1973 only 55% expressed confidence in medicine (Norris 2002; see also Pescosolido 2006). Levels of confidence in medicine continued a gradual decline to 47% in 1990, with only 44% of the American public indicating confidence in medicine in 2000. Similar declines in public confidence in medicine, particularly throughout the 1980s, have been documented in numerous other countries (e.g., Finland, Norway, Spain, Ireland, Sweden, Canada, Britain, Japan, and Germany) (Norris 2002).

With the growing corporatization and bureaucratization of Western medicine, the cost of healthcare has increased, leading to a limited ability for some to access Western medicine and a consideration of alternative therapies (Barnes et al. 2004; Bitcon et al. 2016; Gardiner et al.

2007; Kennedy 2005; Pagan and Pauly 2005). The aging of the American public combined with advances in curing acute illness has led to an increase in the prevalence of chronic illness and pain associated with arthritis, rheumatism, and other maladies (e.g., contested illnesses like fibromyalgia), for which Western medicine has made little advancement in treating; which when combined with public awareness of iatrogenic complications and pharmaceutical side effects, leads to the public's questioning of Western medicine's efficacy and a search for alternative care (Jones 2004; Nissen and Evans 2012; Schlesinger 2002; Siahpush 1999; Timmermanns and Oh 2010; Vuckovic and Nichter 1997). In contrast to Western medicine and pharmaceuticals, many herb users believe that herbs are generally healthy and safe to use (Carlisle 2003; Cushman 2008; Egan et al. 2011; Nissen and Evans 2012).

In contrast to the fragmentary, and sometimes contradictory, nature of constantly evolving Western medical knowledge, the holistic approach characterizing most CAM therapies is attractive to users who are frustrated by the state of medical knowledge (Caspi et al. 2004; Kennedy 2005). Further, the quality of Western medicine doctor-patient communication is characterized by many CAM users as briefer and lacking in attention and respect to patients' accounts and information sharing (Broom and Adams 2009; Hok et al. 2007; Nissen and Evans 2012). Herbal users indicate spending more time with herbal practitioners, during which they are able to share detailed information about their life and health to a practitioner who facilitates conversation and listens to patients' stories (Nissen and Evans 2012; see also Sointu 2006).

The push-pull framework postulates that some people are "pushed" into using CAM because they become dissatisfied with modern medicine (Bishop et al. 2006, 2007, 2010; Kelner and Wellman 1997; Khokher 2009; Vincent and Furnham 1996). This dissatisfaction can take many forms: a rejection of Western medicine's reliance on technology, concern over the invasiveness

of medical interventions (e.g., surgery), and concern over the toxicity of pharmaceuticals. Dissatisfaction may also stem from previous experiences with Western medicine, such as its perceived failure to correctly diagnose or effectively cure a medical ailment, the perception of a limited range of treatment options, the experience of adverse effects from medical therapies (including pharmaceuticals, surgery, and other medical interventions), and poor communication with their doctor. Consequently, some people are thought to seek CAM out of a sense of desperation at the inability of Western medicine to provide relief for their condition (Kelner and Wellman 1997). It is important to note that CAM users' dissatisfaction with Western medical health care is mixed in other research (see Cauffield 2000; Goldstein 2002; LaCaille and Kuvaas 2011).

Despite awareness of all these factors contributing to a growing lack of confidence in Western medicine, there is little research clearly identifying the different forms that dissatisfaction with Western medicine takes in groups of people experiencing different health needs (Broom and Tovey 2007; Mitchell and McClean 2014; Pawluch et al. 2010; Smithson et al. 2010; van Kleffans, van Baarsen, and van Leeuwen 2004; Verboef and White 2002; Yates et al. 2003). Further, fewer of these studies identify the degree to which these reasons for dissatisfaction with Western medicine influence people to seek CAM, much less to initiate the specific use of herbal medicine (Broom and Tovey 2007; Mitchell and McClean 2014; Pawluch et al. 2010; Yates et al. 1993). To contribute to this small, growing body of existing research, this research seeks to explore how situational conditions, such as specific illness experiences and concomitant dissatisfaction with Western medicine, influence people to begin using herbal medicine.

Cultural Influences

Dissatisfaction and distrust of Western medicine may additionally stem from cultural factors, such as values and beliefs associated with the emergence of a postmodern economy and society (facilitated by globalization and characterized by accelerated social change) that paralleled changes in cultural practices. A result of these changes include a rejection of modernism, including the corporatization of healthcare and doctor authority, a valuation of nature and the environment, and an increase in a sense of individual responsibility and desire for control over one's health (Astin 1998; Bakx 1991; Barnes et al. 2007; Coulter and Willis 2007; Cushman 2008; Egan et al. 2011; O'Callaghan and Jordan 2003; Pawluch et al. 2000; Siahpush 1998). Further, concomitant with a decline in organized religion, spirituality, intuition, and reflexivity emerge as correlates with CAM use (Coulter and Willis 2007; Fries 2003; Saher and Lindeman 2005; Sointu 2006). Astin (1998) additionally found that having experienced a transformational life experience that changed the user's worldview was a significant predictor of CAM use. Such cultural and personal factors may 'pull' one towards the use of CAM because CAM is congruent with their worldviews regarding the environment, health, and life (Bishop et al. 2006, 2007, 2010; Kelner and Wellman 1997; Khokher 2009; Vincent and Furnham 1996). In addition, CAM may be seen as more effective for specific ailments, and as a more safe, holistic, and sensible means of health care.

Health- and food-related movements and the concurrent politicization of health that empowers people to take charge of their health further influence people's distrust in medicine and their expression of postmodern values (e.g., individuality, reflexivity) (Broom et al. 2010; Brown and Zavestoski 2004; Coulter and Willis 2004; Ruggie 2005). As a movement towards self-care, Broom et al. (2010) characterizes CAM users as lay activists who are empowered to take

responsibility for their health and to mount epistemological challenges to Western medicine. Users of CAM as part of a self-care regiment have been further characterized as embodied activists, whereby users resist the function of biomedicine's control of the body by way of the embodiment of resistance through self-monitoring and self-care of one's health (Fries 2003; Gale 2014). This embodied health movement is in response to the rise of medical authority, particularly instances where this authority worked against public interest (such as research fraud, conflicts of interest among corporations and medical researchers, and iatrogenic illness) (Brown and Zavestoski 2001). Yet, self-informed, self-healing, embodied activists encounter barriers, including a lack of access to and availability of formal knowledge on CAM, limited time and resources to work more diligently on their health, and, in some cases, an unsupportive response from medical providers (Broom et al. 2010; Golder 2005; Hess 2004). At the heart of embodied health movements are alternative conceptualizations of the ontologies and epistemologies of health, illness, and healing, intertwined with structural, cultural, and personal factors.

Intersection of Factors Influencing the Choice to Use CAM

There are few studies that qualitatively investigate how social, cultural, and personal factors combine to influence an individual to use CAM. Caspi et al. (2004) interviewed twelve patients with chronic rheumatological disorders who either: considered the use of CAM but decided against it, used CAM therapies instead of Western medicine, or used both CAM therapies and Western medicine, and found that participants' choice to incorporate CAM therapies depended upon their levels of trust in their medical provider, the severity of illness experienced, their general openness to experimentation, their exploration of information and knowledge on CAM therapies, their exposure to testimonials and recommendations of CAM therapies, intuitive and spirituality factors, and evidence of CAM's efficacy with regard to their health. These findings

led Caspi et al. (2004) to question whether this population may be termed ‘alternative patients’ rather than just alternative medicine users. Yet, other scholars have argued that the choice to use CAM therapies lies more in pragmatism and their perceived efficacy than in their philosophies or scientific evidence of efficacy (Conrad 2012; Gale 2014; MacArtney and Wahlberg 2014). In any event, users’ choice to pursue CAM therapies is a choice made in an arena of a plurality of medical practices, leading Broom (2009) to characterize CAM users as bricoleurs, or those who use information cultivated from embodied knowledge, social networks, and scientific expertise to intentionally exercise their individual agency and access what they believe is the most efficacious medical therapy in the face of competing health epistemologies and structural constraints.

The Meaning of CAM

There are additionally few qualitative studies that seek to understand how people use and attach meaning to the practice of CAM in everyday life. Fries (2003) interviewed 41 CAM users in Canada to find how CAM use serves as an embodiment of distinction, and found that distinction was pursued by way of ‘high performance lifestyle’ based in self-care in contrast to those whose health care was limited to Western medicine. Sointu (2006) interviewed 31 CAM practitioners and users in England to explore the meaningfulness of CAM use and found that CAM was used to produce well-being, characterized by something natural/inherent to the person, as a means of living life to the fullest, and as a sense of agency in that one chooses who to be, feel, and behave even in the face of difficulties.

Other research on how people use CAM in everyday life focuses on specific sub-groups. Broom et al. (2010) performed 60 interviews and collected 30 diaries from women ages 60-65 in

Australia who used CAM to find how people go about consulting with people and finding information on the use of CAM and how, in result, they incorporate CAM in daily life. Broom et al. (2010) found that knowledge was shared in complex social networks, and that use was connected to large degree of experimentation and self-trialing with CAM therapies. Mitchell and McClean (2014) interviewed 14 pregnant women in England who used CAM and found that their use was a response to the uncertainties involved in pregnancy and childbirth and as a defense against the potential physical and mental risks and ensuing fear and anxiety posed by growing and birthing a human life. Foote-Ardah (2003) interviewed 12 people with HIV in America to discover the meaning of CAM in their lives and found that their use was a means of managing life by increasing personal control over their health, such as by self-regulating their disease progression, obtaining freedom from medical constraints, and managing stigma related to their illness. Pawluch et al. (2000) also sought to examine the meaning of CAM by interviewing 66 people with HIV in Canada, and found that people used CAM to maintain their health; to self-heal on an emotional, mental and spiritual level; to mitigate prescription drug side-effects; and as a form of political resistance.

Socio-Behavioral Model of Health Care Choice

In 1973, Andersen and Newman proposed a model to explain, and potentially predict, the use of different medical inventions that accounts for social and individual factors that influence someone to seek a particular medical therapy. In Andersen's (1995) revision of the model, and in line with its use by Sirois and Gick (2002) to evaluate its usefulness in explaining people's choice to initiate and continue their use of CAM, three categories of factors were delineated: predisposing factors, enabling factors, and health need factors. Predisposing factors refer to demographic factors and personal beliefs and attitudes, such as about Western medicine and with

regard to postmodern values. Enabling factors include those relating to the availability of a CAM modality, as well as knowledge about its use, such as geographical access and the extent and quality of influential people. Need factors refer not only to health status as objectively evaluated, but also as health status and the need for health care are subjectively perceived by the individual experiencing a health need.

Vincent and Furnham's (1996) comparison of osteopath users, homeopath users, and acupuncture users in England highlights the different factors that prompt CAM users to select different CAM therapies. All three user groups expressed predisposing factors such as a positive valuation of CAM treatments, perceived inefficacy of Western medicine for their specific ailment, concerns about adverse effects associated with Western medicine and the quality of doctor-patient communication; and took enabling factors into account (e.g., the availability and accessibility of CAM). However Osteopath users were the least concerned about adverse effects and more influenced by the availability of this therapy, while homeopaths were more driven by their perceptions of Western medicine's ineffectiveness. Vincent and Furnham (1996) additionally distinguished between push factors (including disposing factors such as dissatisfaction with Western medicine) and pull factors (disposing factors such as that CAM was more attractive).

Kelner and Wellman (1997) took a similar approach to employing Andersen's (1995) model to explore how different factors combined in varying degrees to prompt people to seek care from a family physician, a chiropractor, an acupuncturist, a naturopath, or a Reiki practitioner by way of interviewing Canadian users of each medical therapy. Insofar as predisposing factors, CAM users were more likely to be female, younger, live in urban areas, have higher education and income, and to indicate less affinity for religion and a greater belief in spirituality. Personal

enabling factors differed among CAM modalities, with Reiki users indicating a referral as a factor influencing their choice (40%), to only 23% of naturopath users indicating a referral. On the other hand, a previous positive experience with that CAM modality was indicated by 13% of naturopaths to a low of only 8% of Reiki users. In terms of need, 83% of CAM users indicated that their health problem was serious (compared to 76% of family physical users), and 89% said their problem affected their daily life (compared to 67% of family physical users).

Kelner and Wellman (1997) also observed differences with regard to push and pull categories of beliefs about health and illness. When it came to push factors, such as seeking medical therapy out of desperation following the inability of Western medicine to provide relief, 33% of naturopath users indicated desperation, followed by 30% of acupuncture users, 10% of Reiki users, and 9% of chiropractic users. And, when it came to pull factors, such as knowledge and belief in the principles and effectiveness of CAM, 38% of Reiki users indicated a belief in CAM, followed by 30% of naturopath users, 23% of acupuncture users, and 12% of chiropractic users. Finally, CAM users were more active in their health, with 38% indicating they were most able to help their health (versus 15% of family physician users) and only 20% indicating that a doctor was most able to help their health (versus 70% of physician users). This small body of research illuminates the importance of understanding how different reasons for CAM use manifest in different ways depending on the type of CAM therapy sought.

Sequencing of Use Factors

At the time of Siahpush's (1999) review of the Sociology of CAM, there were the only two studies that investigated the process that one goes through to become a committed CAM user (i.e., Sharma 1990 and Semmes 1990, c.f. Siahpush 1999). Sharma (1990) interviewed 30 CAM

users to find the reasons why they turned to CAM therapies and found that most users had a chronic disease that had not been successfully treated by biomedical practitioners, characterized by overall dissatisfaction with the treatment outcome and the doctor-patient encounter. Then, many of the people in Sharma's (1990) study sought information on CAM therapies following recommendations from members of their social network.

Semmes (1990, c.f. Siahpush 1999) interviewed 100 African-American CAM (mostly chiropractic) users in Chicago, IL who experienced chronic pain, and outlined a five stage model of progression to the regular use of CAM therapies. First, users developed a personal inclination to nature-centered and holistic medical therapies, and then the user decided to visit a CAM practitioner. Following their visit with a CAM practitioner, and if the user is satisfied with the experience, they moved into the fourth stage, which entailed the incorporation of CAM practices in their daily life, such as by making lifestyle changes, experimenting with different therapies, and performing further research on CAM therapies. In the fifth stage, users were firmly entrenched in daily use and developed a firm belief in the efficacy of CAM therapies. In contrast to Sharma's (1990) findings, Semmes' (1990, c.f. Siahpush 1999) CAM users began from cultural/personal inclination to try CAM, rather than from unfavorable medical experiences. Under-investigation of the temporal sequence of factors that influence someone to use CAM led Siahpush (1999) to recommend qualitative research to find the causal ordering of variables leading to committed CAM use.

In response to Siahpush's (1999) call for more research, Yardley et al. (2001) interviewed people receiving chiropractic treatment for back pain and, using a grounded theory approach, constructed a theoretical model that linked factors influencing the choice to use and continue CAM. This model highlights the reciprocal interactions between patients' abstract beliefs about

the cause of their illness and treatment, and concrete experiences of treatment (derived from personal treatment experiences and word of mouth success stories); and reciprocal interactions between their perception of symptom reduction and the practitioners' competence. When it comes to research on how people start using herbal medicine, Dougherty's (2004) interviews with American herbalists and other texts authored by American herbalists portray accounts of herbalists' initial foray into herbalism (e.g., see Gladstar 2012; Kloss 1999); however, these accounts are not systematically collected or analyzed to explore the process by which someone starts using herbal medicine.

Continuing CAM Use

In a comparison of initial CAM users, established CAM users, and non-CAM users, Sirois and Gick (2002) found that predisposing factors, such as health awareness and dissatisfaction with Western medicine, were most salient in both CAM using groups, followed by the perception of treatment efficacy for the given ailment and quality of practitioner and patient communication. Need for treatment of a medical ailment was also indicated for both new and continuing CAM users, though this factor was more salient in continuing CAM users, while an openness to new experiences was more characteristic for new CAM users. Baarts and Pederson (2009) interviewed 46 CAM users in Denmark to find why they continued the use of CAM and found that they did so to address emergent health issues and to improve general health. In addition, Baarts and Pederson (2009) identified derivative benefits from the continued use of CAM, such as heightened self-reflection, greater control over their health, and a concomitant sense of well-being from awareness and mastery over their mind and body.

To address the theoretical lacking that characterizes much of the research on why people use CAM, Sirois, Salamonsen, and Kristoffersen (2016) surveyed 159 college student CAM users to discern why they continued or discontinued CAM use by way of testing a brand loyalty model. They found that positive outcomes with CAM treatment, a fit between the epistemology of the CAM treatment and the user's values and beliefs, and a fit between the CAM therapy and its ability to heal a particular ailment were positively correlated with continued commitment to CAM use. This small body of research provides evidence echoing Vincent and Furnham's (1996) call to separate factors that propel one to start using CAM from those that influence someone to continue using CAM as, for instance, the perceived effectiveness of CAM and beliefs about health and illness prior to use are likely to change depending on someone's experiences with CAM.

SUMMARY

Existing research has uncovered numerous reasons why people are increasingly turning to CAM in recent decades, including structural changes in medicine and the economy; beliefs about health, illness, and medicine reflected by and stemming from structural changes and social, cultural, and personal factors; personal and word-of-mouth experiences of illness, health, and health care; knowledge of CAM therapies; and availability and accessibility of Western medicine and CAM therapies. While there is a growing body of research that addresses how these factors combine to influence someone to select a particular CAM therapy, and few studies that aim to explain the sequencing of factors leading one to use CAM, there is no identifiable research that specifically seeks to adequately contextualize and understand the process of how different factors combine in differentially experienced sequences and varying degrees of influence upon a person's choice to start using herbal medicine in America. This research aims to delineate this

process and add descriptive depth and detail to existing accounts of herbal medicine use in America.

RESEARCH QUESTIONS

Reviewing recent literature confirms how little social science research exists with regard to motivations to start using herbal medicine. To take up the challenge of understanding how people make a choice to begin using CAM (Baer and Coulter 2008); and in response to Siahpush's (1999) call for more qualitative research to delineate the temporal sequence of factors leading to the use of CAM, this study seeks to uncover how current, regular (i.e., daily) herbal medicine users made the choice to start using herbal medicine. In so doing, this research will contribute to the growing body of scholarship in the Sociology of CAM that aims for a detailed understanding of the process by which American adults are increasingly choosing to use specific CAM therapies during a period characterized by conflict between WHM and Western medicine in the movement towards integrative medicine.

This research seeks to understand why and how regular herbal medicine users initially chose to use plants for medicine. In particular:

- 1) How do herbal medicine users learn about, become interested in, and actually begin using herbal medicine?
 - a) How do social, cultural, personal, and situational factors uniquely combine to influence regular herbal medicine users to first begin using plants for medicine?
 - i) In what order do herbal medicine users experience these factors?
 - ii) What degrees of influence do these factors exert on the user?

Understanding how people who regularly use herbal medicine began using herbal medicine can uncover influential factors that are unique in their influence upon herbal medicine users compared to other CAM therapy users so that a deeper understanding of present-day CAM and herbal medicine use is achieved, as well as how people make health care choices during a period characterized by Western medical dominance over the plurality of medical treatments available in present-day America. Understanding the sequence of factors that lead people to pursue herbal medicine use can uncover how people develop beliefs and attitudes about Western medicine that lead them to seek other forms of medical treatment, such as how specific illness experiences and Western medical experiences prompt different forms of dissatisfaction with Western medicine, and thereby inform the movement towards integrative medicine. Understanding how people learn to use herbal medicine despite the marginalization of professional herbalist practices and little accessible reliable scientific evidence to guide how people use herbal medicine can inform regulations with regard to the use of herbal medicine in order to ensure that adequate information is available to guide the use of herbal medicine in the absence of professional guidance as well as medical doctors who wish to pursue the practice of integrative medicine.

In order to find why and how people began using herbal medicine, I performed 28 intensive face-to-face interviews with current, regular (i.e., daily) herbal medicine users in Cincinnati, Ohio (n=14) and St. Louis, Missouri (n=14) using a semi-structured interview guide that focused on soliciting participants' accounts of why and how they began using herbal medicine. I additionally prompted for details about users' experiences with Western medicine and how they learned about the use of plants for medicine. A qualitative approach will provide depth and detail to the existing body of research that seeks to understand how different factors intersect and influence people to begin using herbal medicine.

In chapter 2, I will describe the methods employed to answer these research questions. In chapter 3, I will describe how participants developed an interest in herbal medicine following social and cultural influences and experiences with herbal medicine that accumulated throughout the life course and set the stage for many participants' use of herbal medicine. Chapter 4 will address the influence of situational conditions, including illness experiences, a lack of health insurance, and pregnancy that, in many cases, contributed to dissatisfaction with and other beliefs about Western medicine that further fueled, and in some cases initiated, participant's choice to use herbal medicine. Chapter 5 will discuss the findings of this research within in the larger body of research on people's use of CAM and herbal medicine and conclude this dissertation with a discussion of the limitations of this research and directions for future research.

Chapter 2: Methods

INTRODUCTION

Much of the existing research that seeks to understand why people use CAM is characterized by a quantitative approach, such as by using surveys. The use of surveys often takes an objectivist, deductive approach by asking participants to organize the complexity of their human experiences into categories that are pre-determined by the researcher(s) (Warren and Karner 2010:9). In contrast, most qualitative research is characterized by a subjective, often inductive approach, whereby experiences and meaning are derived from observation, interviews, and texts. As explained by Denzin and Lincoln (2008), “qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self” (p.4). I collected each of these representations of participants’ experiences with herbal medicine in this research. In order to answer the question of why and how herbal medicine users began using herbal medicine, I conducted intensive interviews with 28 adults in Cincinnati, Ohio (n=14) and St. Louis, Missouri (n=14) who regularly used a diversity of herbs and herbal supplements for health and well-being in the past year.

I maintained a qualitative approach situated in a constructivist-interpretive paradigm.

Constructivist ontology as employed in qualitative research posits that people apprehend and experience the social world subjectively, and interpretive epistemology recognizes that the researcher’s interpretation of participants’ constructed experience stems from the researcher’s personal background (Creswell 2013:22-25). Thus, the constructivist-interpretive paradigm

requires the researcher to interpret how participants experience, understand, and assign meaning to the social world in different ways (Creswell 2013; Denzin and Lincoln 2008:5-10). In this way, meaning is co-constructed between the researcher and participant during communication. The constructivist-interpretive approach allowed me to reflexively interpret how participants constructed their entrée into first using herbal medicine and the meaning that this choice has for them, and to represent interpretations of participants' accounts in order to discern patterns in participants' experiences and achieve an understanding how people start using herbal medicine.

Relying primarily on face-to-face intensive interviews added interpretive depth and detail to pre-existing quantitative survey work in this area of research. This research method allowed me to solicit participants' accounts of how they first starting using herbal medicine and probe for additional details about their experience, including the influence of social, cultural, personal, and situational factors upon their choice to start using herbal medicine, knowledge sources that participants relied upon to learn how to use herbal medicine, and the extent to which experiences with and beliefs and attitudes about Western medicine influenced their choice to begin using herbal medicine. Participants' narrative accounts of why and how they chose to begin using herbal medicine unveiled the sequential order of the influences they experienced, as well as the relative importance of each of these influences upon their use of herbal medicine.

I utilized multiple methods in this research. I recorded detailed field notes after each audio-recorded interview with participants, observed and participated in the use of herbal medicine and related activities, recorded aspects of the process of using herbal medicine with photographs, and drafted memos throughout the process of collecting, analyzing, and writing about the data collected to document the research process. The use of multiple methods allowed me to collect various means of representation of the process that participants engaged in to use herbal

medicine so that I could come to a more comprehensive understanding and interpretation of this practice as experienced, recollected, and recounted by participants.

METHODS

Selecting Interviewees

In order to find how medicinal plant users first began using herbal medicine, I sought participants who used a diversity of herbs or herbal supplements for health and well-being on a daily basis in the past year and who resided in or near Cincinnati, Ohio and St. Louis, Missouri. Purposeful sampling of interviewees from the larger population of current, regular herbal medicine users allowed me to investigate how participants first started using herbal medicine and how they continued to use herbal medicine up to the time of interview. I had no additional criteria for inclusion in this study with regard to demographic characteristics, how long participants had used herbal medicine, or why or how people used herbal medicine (e.g., such as to treat a health condition, for nourishment, or in line with different herbal traditions).

Interviewing in both Cincinnati, Ohio and St. Louis, Missouri was convenient because I established partial residence in each of these cities during the interviewing phase of this research, which allowed me to access and navigate both cities with ease. Cincinnati, Ohio and St. Louis, Missouri are demographically-comparable mid-sized Midwest river cities with historically variable support for the professional practice of herbal medicine. Both cities have similar demographic compositions with regard to population, age, race, income, and education (U.S. Census 2015). At the turn of the 19th century, Cincinnati and St. Louis were two of only 6 cities in the Midwest that boasted an eclectic medical college where doctors who specialized in the use of herbal medicine were professionally trained (Haller 1999). While the St. Louis eclectic

schools were very short lived, the Eclectic Medical Institute in Cincinnati operated for 94 years, from 1845-1939. Interviewing in these two cities allowed me to recruit participants from a larger population of herbal medicine users in the Midwest, as well as to interview while living in Cincinnati to research at the Lloyd Library and Museum during my Curtis Gate Lloyd Research Fellowship and while frequently visiting (and ultimately moving to) St. Louis City to be closer to my family as they experienced health needs that prompted additional care.

Recruitment

Following University of Kansas, Lawrence Human Subject Committee Approval of this research, I finalized the Consent to Interview and Photo Solicitation forms and developed a recruitment flyer and solicitation text (see Appendices A-F). I also developed my personal webpage at the University of Kansas (see <http://people.ku.edu/~rachelcr/>) to include information about my research. I performed three pilot interviews with herbal medicine users in Lawrence, Kansas in May 2013, until I felt the interview guide achieved internal validity. During June and July 2013, I posted recruitment flyers and left business cards containing my contact information at health food and herb stores, herbal and other CAM practitioner offices, and other businesses and organizations that offered herbal products and information on the use of herbal medicine (including the Lloyd Library and Museum, cafes, and coffee houses) within the greater Cincinnati city area. I also emailed my recruitment text to herb societies and groups operating within the Cincinnati area.

I additionally relied upon snowball sampling, whereby I solicited participants through people that I met, whether we met by chance, by way of recruitment efforts, or through their participation in the research. After contacting formal gatekeepers, including owners, managers,

and directors of the businesses and organizations where I posted recruitment flyers and emailed solicitation texts, they also forwarded information about this research through email lists and Facebook groups to herbal medicine users. I was in contact with 25 herbal medicine users in Cincinnati, Ohio, and interviewed 14 people during June-July 2013. Eleven interviewees contacted me after receiving information from another person who forwarded them information about this research, and three interviewees contacted me in response to seeing recruitment flyers. The majority of those whom I was in contact with but did not interview indicated limited availability during the June and July 2013 because their children were home from school, they were working long shifts in seasonal occupations (e.g., in agriculture), or were travelling out of the Cincinnati area. After recruiting three participants from one snowball chain, I discontinued snowball sampling from that source so that I could gain a more diverse sample of participants.

Recruitment in St. Louis, Missouri began in September 2013 and continued through March 2015. Recruitment in St. Louis proved more difficult than in Cincinnati because I was physically present in the city during approximately two weekends a month throughout 2013-2014. I duplicated my recruitment strategy in the St. Louis City area by posting recruitment flyers and leaving business cards containing my contact information at health food and herb stores, herbal and other CAM practitioner offices, and other businesses and organizations that offered herbal products and information on the use of herbal medicine (including cafes, coffee houses, and an herb plant sale). I also emailed my recruitment text to herb societies and groups within the St. Louis City area. I additionally contacted individuals who indicated their use of herbal medicine on business cards they left in establishments where I posted flyers, and solicited participants through my personal social networks. I was in contact with 27 people who used herbal medicine in St. Louis, and interviewed 14 people from December 2013 to June 2015. Nine interviewees

contacted me in response to seeing recruitment flyers or receiving an email of recruitment text forwarded through herbal organization and group email lists, two responded to my email in response to seeing their business card, two responded to snowball efforts through my social networks, and one interviewee responded to a snowball from a participant. Herbal medicine users that I was in contact with, but did not interview, were largely unable to meet with me because of time constraints and scheduling conflicts.

Cultivating trust while recruiting

Recruitment in both cities was complicated by potential gatekeepers' and participants' concerns about the motives for this research. Concerns generally fell into one of two categories: concern over the exploitation of information gathered for herbal and pharmaceutical industry and advertising purposes, and concerns over my portrayal of herbal medicine users as “crackpots,” “quacks,” or “witches.” For instance, when I visited a small nutritional supplement store in Cincinnati, Ohio and asked to leave a recruitment flyer, the store clerk asked if I was with a pharmaceutical company and said that he would check with the manager about whether they would post the flyer. Despite my assurances that I was unaffiliated with industry and was an herbal enthusiast who wanted to learn more about how people start using herbal medicine, the flyer was not posted in public view when I returned to the store the following week.

After a number of people inquired about the motives underlying this research, I updated my personal University of Kansas webpage to include additional information. This included accounts of my academic background and research interests, publications, participants' rights in research, my commitment to confidentiality and anonymous reporting, the purpose and goals of this research, and personal photos and additional contact information. This information seemed

to allay some participants' concerns as the people I contacted about this research following this act voiced less suspicions about my motives. For instance, as recounted by memory in field notes, one participant started the interview by asking, 'What is your research about? I looked at your website this morning but didn't have time to see much of the site. I was concerned you would be supercritical like some people... But then I saw your picture on your website and I knew you wouldn't be critical.' Providing more information about me, both personally and academically, and about the research allowed potential participants to better connect with me and the research and aided in cultivating participants' trust that the findings of this research would not be used for advertising or derogatory purposes.

Interviews

I asked to interview participants at a location where participants grew, processed, used, or found information on herbal medicine, which included homes and, particularly in the case of professional herbalists, places of work. I assured participants that all identifying information collected would remain confidential and that I was not at all concerned about the condition of their homes and places of work. I also let participants know that they could select a different location to interview at. Interviewing where participants used herbal medicine allowed me to observe how they used herbal medicine, such as by viewing their herbs and herbal supplements, items used in the process of using herbal medicine (including tea kettles, plant drying racks), herbal plant gardens, and sources of information about the use of herbal medicine, such as books and other texts (see below for more information on participant observations). Interviews predominately took place in people's residences (n=18), followed by businesses where herbal medicine was grown or sold, such as farms and health food and herb stores (n=8), and at a café close to the participants' residences (n=2). Despite concerns over safety and access when

interviewing in private areas, such as people's homes (see Lofland et al. 2006:27-34; Warren and Karner 2010:45), no concerns for my personal safety surfaced and participants overwhelmingly welcomed me into their homes and places of work.

I conducted 28 face-to-face in-depth intensive interviews: 14 in Cincinnati, Ohio and 14 in St. Louis, Missouri. I continued interviewing in Cincinnati until I was no longer able to maintain my residence there, which additionally coincided with fewer people contacting me for information about the research and to participate. I continued interviewing in St. Louis until I reached my target of matching the number of interviewees in Cincinnati and themes that emerged from the interview data began to repeat and saturate thematic coding categories that emerged from data analysis. Thus, both methodological and structural factors operated to end the interviewing phase (Lofland et al. 2006:76). In short, I started to learn less novel information, I alternated living in three different cities throughout the course of this research, and my deadline for submitting this dissertation was approaching.

Twenty-four interviews were one-on-one, in which I interviewed a single person, and two interviews were with dyads, where I interviewed two people at the same time (i.e., a couple and two friends). In both cases where I interviewed dyads, the participants requested this interview format. I honored their request because I did not foresee that interviewing two people at the same time would affect the quality of data collected and it allowed me to gain experience interviewing more than one person at the same time. Interviews with single participants ranged from 1-4 hours in length, while interviews with dyads were roughly 4-5 hours long. While I limited my recruitment efforts to the greater Cincinnati City and St. Louis City limits, I interviewed several participants at locations outside of the city limits, such as at farms located in adjacent rural areas.

Interviews began with an introductory script that identified why I am doing this research, a review of consent forms, and a roadmap for interview questions.

As you know, my name is Rachel Craft, and I am PhD student in the Department of Sociology at the University of Kansas. I have experience researching herbal medicine through my Graduate Research Assistantship with the Native Medicine Plant Research Project at the University of Kansas. During the course of my research I began to wonder why people are increasingly using herbs for health and well-being. So, I decided to research why and how people use herbs and herbal products for my PhD Dissertation. I am very excited to learn more about your experiences with and use of herbs and herbal products, and I hope that my research findings will shed light on the question of why people use herbs for health and well-being, and perhaps even inform policies regarding the public's use of herbs. Before we begin, I would like to review Consent to Participate documents with you. (Review consent documents and address any questions.)

I would like to begin by asking you a few questions about your diet, health, and use of different medical therapies, then I would like to ask you to tell me the story about how you first started using herbal medicine. After that, I have a few more questions about how you continued to use herbal medicine, how you use herbal medicine, and I will ask for your thoughts about related topics, such as whether you believe there is a movement for herbal medicine in America. At the end of the interview, if possible, I would like to observe the process that you go through when you use herbal medicine, such as by viewing the herbs themselves, items that you use when preparing herbs, your garden, and any books or other information sources that guide you in the use of herbal medicine. I will also ask you to fill out a brief demographic survey and to identify what herbs are most important to you. Do you have any questions before we begin? Is it okay for me to begin audio recording?

Interview guide

I developed a semi-structured interview guide that consisted of open-ended questions organized into four sets (see Appendix G for the Interview Guide):

1. Snapshot of Herbs, Health, Diet, and Use of Medical Therapies
2. Story of Becoming a Medicinal Plant User
3. Thoughts on Movements, Voting, and Cannabis
4. Describe and Demonstrate Herbal Medicine Use

Within each set of questions were 4-11 main questions, each with additional probes, or ideas for further exploration, that I would consider asking as participants answered each question (Seidman 1998:68; see also Lofland et al. 2006:102-103). Probing for additional information allowed me to gain a deeper understanding of how participants constructed their experiences and thoughts with regard to their choice to use herbal medicine and to generate richly detailed data about their use of herbal medicine. I placed the most basic and least intrusive questions early in the interview guide, such as how participants characterized herbal medicine, described their diet and health, and used other Western medical and CAM therapies (Lofland et al. 2006; Warren and Karner 2010). Potentially sensitive questions, such as their thoughts about social movements relating to herbalism, voting, and views on the legalization of *Cannabis*, were placed near the end. Prior to asking potentially sensitive questions, I informed participants that I was going to ask a couple questions that might seem controversial, and reminded participants that they were free to decline answering any questions at any time during the interview. No participants refused to answer these questions. Only a portion of the findings from these interview questions are reported here because a detailed discussion of how participants continued using herbal medicine over the years and of how participants use herbal medicine in their everyday life are beyond the scope of this dissertation.

While interview questions were organized into sets of questions that I intended to ask in sequential order, our conversations often spanned and encompassed many topics at once (Lofland et al. 2006:105). Further, many participants began discussing how they first started using herbal medicine in response to questions that I asked prior to soliciting participants' narratives of how they started using herbal medicine. For instance, when I asked Allen to describe his health, he responded, "Okay, so, to dig further into this thing, can I tell you about

the origin of getting into herbal medicine? Because to explain, it's almost like I have to get back to what caused it." I took careful notes on emergent themes and topics so that I could follow up on them later in the interview. I also began leading interviews with questions from the second set in the interview guide because participants' stories of how they started using herbal medicine continued to come up early in the interview. Our conversations about participants' first use of herbal medicine seemed to function as a bonding moment that increased rapport and trust during the rest of the interview.

Cultivating trust during interviews

During interviews I had to acknowledge my simultaneous roles of being a convert (i.e., already being an herbal medicine user) and being a dispassionate scientific observer. In line with the interpretive epistemology underlying this research methodology, I was careful to minimize interpreting participants' experiences and understanding of herbal medicine in relation to my own experiences and understanding of herbal medicine so that I could guard against the drawbacks of being a convert, namely to be able to understand participants' varied experiences with and conceptions of their herbal medicine use independent of my own experiences with and conceptions of herbal medicine (Lofland et al. 2006). In so doing I was better able to align myself with the principals of the constructivist-interpretive approach to qualitative interviewing, particularly exploring and understanding unstated and assumed meanings of how participants thought about and used herbal medicine (Lofland et al. 2006:22; Charmaz 1996).

I employed two presentational strategies in order to avoid the drawbacks of being a convert and to acknowledge the influence of my worldview upon interpretation of participants' accounts: acceptable incompetence and selective incompetence (Lofland et al. 2006:67-75). As a form of

acceptable incompetence, I assumed a student role and asked for clarification of ideas and thoughts as they came up in conversation, such as by asking, “What do you mean by _____?” By assuming this student role, I also hoped that participants would share their experiences using their inner voice, which is the less inhibited and more personal voice we use to talk to people who are close to us and/or who we trust, in contrast to the briefer and more direct outer voice that we use to talk to strangers (Seidman 1998:64).

Many participants asked me if they were making sense or if I understood what they were saying during interviews. And some participants hesitated before discussing their experiences with Western medicine and affinity for different CAM therapies, presumably out of concern that I would judge them in a negative manner. As a form of selective incompetence, I selectively revealed what I believed and knew about the use of herbal medicine (Lofland et al. 2006:70).

For example, in response to participants’ questions about whether what they said made sense and hesitations in sharing their views on different medical therapies, I responded by telling them how I interpreted their words, indicated my personal agreement, and/or responded with similar ideas or feelings that I had or that other participants expressed. By employing the tactic of selective incompetence, rapport and trust during interviews seemed to improve and participants became more forthcoming in detailing their experiences and thoughts about their use of herbal medicine.

I also employed the strategy of presenting myself with a nonthreatening demeanor (Lofland et al. 2006:68-69) so that I could develop trust and rapport with participants. As described above, some potential participants and gatekeepers indicated a degree of suspicion and distrust about the motives of this research, and some interviewees presumably wanted to avoid negative evaluations of their thoughts and feelings about different medical therapies and their use of herbal medicine. I was careful to appear nonthreatening, such as by behaving in a very courteous

and respectful way while talking to people about this research and while interviewing participants. I observed the norms of households and workplaces and conformed accordingly, such as by removing my shoes upon entering residences where household members did not wear shoes, being careful to cap pens so that ink did not stain furniture or carpets, and taking care to accommodate participants' need to attend to children present at homes and matters at work, or to take rests from conversing during interviews. It was not difficult to feign interest in what participants discussed with me because, as a convert and a social scientist, I was genuinely interested in everything that we discussed.

My ascribed status as a petite, relatively healthy and young white woman likely contributed to participants' impressions of me as a nonthreatening guest in their homes and places of work. Further, my appearance during face-to-face recruitment and interviews consisted of casual dress, typically in earth tones, and dreadlocked hair, which is widely known to be a natural hairstyle. In short, my physical appearance confirms the stereotype of someone who shares an affinity for the natural world, gardening, and the use of herbal medicine. As discussed above, the inclusion of personal pictures on my University of Kansas website engendered a degree of trust and rapport with at least one participant.

By way of employing the presentational strategies discussed above (which additionally coincided with my personal self-concept), I hoped to encourage participants to be forthcoming and honest in sharing their experiences, information, and thoughts about their use of herbal medicine with me. I have no reason to doubt the authenticity of participants' accounts of why and how they use herbal medicine. Nonetheless, it is possible that distrust still played a role in whether or not potential participants agreed to interview with me, whether participants withheld information or experiences during interviews, and whether gatekeepers went on to share information about my

research with others. As described above, at least one natural products store employee expressed concern about the motives of this research by asking me if I worked for the pharmaceutical industry. During interviews, some participants were reluctant to share information about their preferred brands of herbal supplements. Upon reflection, I realized this reluctance likely stems from the concern that the information I gathered could be exploited for commercial purposes. I added a reminder in the Interview Guide to let participants know that I did not intend to publish information about how participants selected particular brands in a way that could be used for advertising or marketing purposes. All participants expressed support for the overall interview structure and comprehensiveness of our conversation when I inquired about whether my questions were appropriate and comprehensive at the end of each interview.

Concluding the interview

Towards the end of the interview I asked participants to identify some of the herbal medicines that were most important to them. I recorded the names of the plants and herbal supplements, what participants used them for, the forms in which participants used the herbal medicine (e.g., in teas/infusions, capsules, tinctures), how frequently participants used the herbal medicine (e.g., as needed, daily, in the morning or at night), and whether or not participants believed this herbal medicine was effective for the purposes intended in a blank worksheet (Appendix H). No participants refused to indicate their most important herbal medicines; however, time constraints prevented 3 participants from completing this task. I entered data collected on the most important herbs used by 25 participants in a Microsoft Excel spreadsheet and descriptively analyzed the data for presentation in the form of a table (see Appendix I for a frequency distribution of the most important herbal medicines identified by participants.)

I additionally asked participants to fill out a demographic survey (Appendix J) that asked participants to indicate their area of residence, year of birth, ethnicity, gender, level of education and areas of study, occupation, religious and spirituality affinity and affiliation, and political affiliation (see Appendix K for an aggregate summary of participants' demographic information.) While all participants complied with this request, several participants were reluctant to indicate their individual income (n=5) and household income (n=7). This reluctance to indicate income may also reflect a concern over the potential of these findings being used for commercial purposes.

Participant Observation

After the interview, I asked participants if I could observe and document how they use herbal medicine. Following 20 of the 28 interviews conducted, participants shared various aspects of herbalism with me, such as by showing me items involved in the process of using herbal medicine. These items included the plants themselves (in gardens, growing wild in their neighborhood, harvested and dried plants that were hanging from their ceiling, laying on shelves, or in mechanical plant and food dryers), and herbal preparations (including tinctures, infusions, herbal blends, herbal capsules, and essential oils). I also viewed items used in the process of making herbal medicine, including tea kettles, jars, plant presses, and liquids used to extract medicinal components from herbs (e.g., oils, vinegars, and alcohol solutions). Lastly, I viewed items that informed participants' use of herbal medicine, including books, magazines, videos, brochures and handouts, and web sites. Sometimes participants brought items to me, and other times we walked through their garden, neighborhood, or to where they practiced herbal medicine, such as places in participants' homes and herb stores that were dedicated to processing herbal medicine. These places included rooms at herb stores and in participants' homes, in spare

bedrooms, basements, attics, and garages. See Figure 2.1 for examples of how participants stored their herbal medicines on shelves in dedicated areas of their homes.



Figure 2.1: Participants' storage of herbal medicine on a shelving unit in a dedicated area of their basement (left; 2013) and their kitchen (right; 2014).

I also participated in activities relating to herbalism. In some cases, I participated in herbal medicine use during the interview, such as when participants offered to share an herbal infusion (also known as tea) with me. I also participated in plant walks, guided meditation, and in using diagnostic tools available at health food and herb stores. I asked to take photographs of items that participants showed me so that I could add depth and visual representation to my observation of their practice of herbal medicine (though the utility of this practice was later revealed to be beyond the focus of this dissertation upon how people make the choice to use herbal medicine). I asked participants to review each photograph that I took to ensure that they

were satisfied with the image and assured participants that I would delete the image if they were unsatisfied with it. No participants asked me to delete a photograph. However, I did crop a couple photographs because I inadvertently captured personal or identifying information (e.g., such as a photograph that included a portrait of a participant's children on the shelf where their herbal books were stored and another where I captured a banner with the name of a participant's herbal company on the wall above a bookshelf containing herbal medicines).

Field Notes

I wrote field notes within hours of the end of each interview so that I had a lesser chance of forgetting details about the interview and participant observation (Lofland et al. 2006:108-109; Warren and Karner 2010:111-112). Field notes took five general forms: accounts of exchanges with people, thick descriptions, analytic memos, process memos, and personal thoughts (Lofland et al. 2006:108-117; Warren and Karner 2010:107-125). Accounts of exchanges with people consisted of notes taken while conversing with participants prior to or following the interview. I also took notes during or immediately following conversations with people that contacted me and expressed interest about the research but who were unable to participate, and with gatekeepers, including health food and herbal store employees, professional herbalists, and people in leadership roles at herbal organizations. For instance, as logged after a phone conversation with a potential participant:

I just returned a phone call from Nancy who left a voice mail yesterday inquiring about the research. She didn't seem to know who I was or why I was returning her call. She seemed interested in the research in a general way, but said that she was very busy. She was a single mother and had a daughter with health issues who was home from school over the summer. She said she was working every day until I leave [Cincinnati]. She said that she might be able to do a short phone interview in August if I really needed to talk to her. She did not want to give me

her email so that I could send her additional information about the research. I am not so sure that she really wanted to interview with me. I do not think that I will reach out to her next month as I feel that I may be imposing on her already very busy life and [I] am ill-equipped to interview over the phone. (6/28/13)

Thick descriptions (see Geertz 1973) included detailed descriptions of what I saw and heard at locations where we interviewed and I observed the process of herbal medicine use, the general comportment and demeanor of the participant, items used in the process of preparing and using herbal medicine, and the character of our interactions.

She had a beautiful home with a lot of exposed wood, earth tones, and country style décor. Artifacts lined the walls alongside books and stones. She had no air conditioning and worried that it might be too hot inside the house, but I assured her I wasn't too warm. Cats watched us, curious of my being there, and scented candles were burning (cinnamon, perhaps also cedar). I sat to the side of her, with a small table between us with a soft light shining on the [audio] recorder; and she sat in a rocking chair in front of the windows, wearing sandals and a flower dress. She was very spirited and forthcoming, and extraordinarily courteous in offering me tea and ensuring my comfort. She brought herbal books to me throughout the interview and was excited to examine them with me. As the sun started setting we walked through her garden, from patch to patch of herbs and foods (onion, garlic, mint, grapes, sweet grass), while I dodged mosquitoes, asked questions, and took pictures and notes. We pondered the beauty of the large walnut tree in her yard. Inside, we went to the kitchen to look at herbal products in a medium size woven basket. She lined the countertop by the sink with dried plants and herbal blends in a ceramic bowl, glass jars, plastic bags, and bundled in cloth and twine. We went row by row through her vast collection of books occupying the bookshelves that lined her living room walls, including books on cooking, herbalism, do-it-yourself living, Wicca, and more. (7/16/13)

Analytic memos focused on general brainstorming with regard to analyzing data, and included identifying and mapping emergent themes, clarifying themes, identifying topics to research further, and bridging emergent themes with existent research. Process memos consisted of personal reflections on the interview and observation process and my role as a researcher, such as on strategies to guide conversations during interview and my behavior while meeting people

in their homes and workplaces. In some cases analytic and process memos overlapped, such as in the following passage:

People keep referring to herbal knowledge and personal experience when I ask how they learn to use herbal medicine. Yet, these categories are different, but still overlapping. I find the herbal knowledge very interesting on a personal level, to learn about plants I haven't always heard of and the ways that they can be used to heal. But this information about how herbs can be used for specific purposes is more ancillary to this research and fitting for a text describing the medicinal use of plants than the focus of this research about how people personally learn the knowledge of how to use medicinal plants. I should remember to probe further on the process of how people come into this knowledge, which in many cases refers back to experiences with plants in which people learned these different uses for different plants. Ask more about how people learned that use for that plant... where exactly did they get that knowledge from (how did they uncover this knowledge), how exactly did they follow through on that knowledge and incorporate it into their use of herbal medicine? Research more on the role that experiential knowledge has for do-it-yourself herbalism. (7/25/14)

Personal responses and reflections were of three types. I recorded my thoughts and feelings with regard to participant observation. For instance, following participation in guided meditation, I reflected on how, "even if I am skeptical, I have to always remain open-minded and try to participate to the best of my ability. Close my eyes and take the deep breaths, focus on the white and gold light from the creator weaving through my chakras." Secondly, I reflected upon the knowledge that participants shared with me, such as when I learned a new use for a medicinal plant that I had experience using or after researching information and resources that participants recommended to me. Lastly, I reflected upon my personal life insofar as it impacted or was impacted by my research. At the heart of this last category of personal reflections was the blending of boundaries between my personal and professional life, a boundary that became more porous the more than I engaged in this research. Field notes were transcribed from hand-written

text into a Microsoft Word document or were contained in a single notebook dedicated to this purpose so that I could review and refer to them more easily during analysis.

Tokens of Appreciation

Participants were courteous and generous during interviews. Many participants offered herbal infusions during the interview (or other beverages) and went to great lengths to ensure my comfort. In addition to allowing me into their homes and work places and taking the time to share their experiences with herbal medicine with me, some participants also gave me small gifts that related to herbalism. These gifts ranged from freshly picked and dried plant materials, homemade herbal preparations (such as tea blends and salves), informational papers and videos, and a black tourmaline stone (to ward off bad energy while living in Cincinnati). In one interview, I was gifted with clothes that the participant was giving away and insisted, despite my admissions to the contrary, would look very good on me. I initially responded to participants' offerings by indicating that I sincerely appreciated them, but that their sharing of experiences and information was the greatest gift I could accept. In all cases, participants persisted and, out of appreciation and so as to not appear rude, I graciously accepted their gift.

I did not have funding to offer participants remuneration, so I offered tokens of my appreciation for their time taken to share their experiences with me depending on the opportunities I found to do so (Seidman 1998:59). During my work as a Graduate Research Assistant at the Kansas Biological Survey, I participated in a harvest sustainability study on a medicinal plant called oshá (*Ligusticum porteri*) in Colorado (see Kindscher et al. in press, 2013). We harvested nearly 100 pounds of dried oshá root during the course of this research, much of which was gifted to research volunteers (who assisted in digging up the roots) and neighboring Native American

communities (who traditionally used the plant for medicinal purposes). I was allowed to have a small portion of the roots collected to give to participants who indicated an interest in this particular medicinal plant. Thus, when participants mentioned their use of oshá during interviews, I offered to mail them a few ounces of the dried root. I also offered to share herbal information resources that I collected during interviews and via my personal experiences with herbal medicine, to provide refreshments while interviewing at cafés, to assist in copy editing a participant's research paper that we discussed after the interview, and to assist in locating research studies that a participant discussed during interview but did not have institutional access to. Finally, after losing my pens during some of my initial interviews, I bought a bundle of pens from the Lloyd Library and Museum and offered this souvenir pen for participants to keep after they used them to fill out the demographic survey.

I offered to send participants a copy of this published research, and all participants expressed interest in seeing the final products of this research. After this research is published, I will follow up with all participants and email a PDF copy of this dissertation to them. I will solicit and accept participants' feedback on the findings of this research and consider their feedback while drafting additional manuscripts from this data. In this way, I hope to achieve member validation and to increase the authenticity of my interpretation and analysis of the information that I report (Seale 1999). I followed up with participants after each interview with a formal note indicating my appreciation for their time taken to interview with me.

Data Storage and Security

I uploaded, labeled, and catalogued auto-recordings and photographs onto my password protected home computer and USB drive. Following concerns that I might lose access to the

data stored on the University of Kansas secure cloud storage following graduation, I maximized security settings on my dropbox.com cloud storage drive and maintained a duplicate of all data there. All papers related to this research (i.e., consent forms, demographic surveys, lists of herbs participants used, transcripts, and other materials) were stored in a locked filing cabinet in my home or University office. All personal and identifying information were stored separately from other data. To maintain a high level of confidentiality and anonymity, all demographic data is reported in aggregate and pseudonyms are used throughout this publication in place of participants' actual names.

Interview Transcription

I transcribed each interview verbatim, in full, using the Dragon Naturally Speaking speech to text program (v12.0). I trained the software to recognize my voice by verbally reading lengthy passages to the program and allowing the program to read previously drafted written materials related to this work. I transcribed the interviews while wearing a headset with a microphone attached. I listened to each interview's audio-recording, adjusted the speed of the interview's playback so that I could easily follow our conversation, and then verbally repeated our conversation into the microphone for the program to convert into text in a Microsoft Word processing document. Through a constant process of additional voice training, adding specialized words to my user voice profile in the program (such as names of specific plants and medical conditions), and frequently updating my user voice profile by way of an automated command in the program, I ultimately reached an 80-90% accuracy rate. After I completed the process of using the Dragon Naturally Speaking program to initially transcribe the interview, I listened to each interview 2-3 additional times to make corrections to mistakenly transcribed text, to fill in words missing from the transcription, to add punctuation and time stamps, and to

document things like long pauses and laughter. Each interview took roughly 3-4 times the length of the recording to transcribe.

Interview Data Analysis and Coding

I analyzed interview data by way of thematic coding. I first open coded, line by line, all interview text using pencil on paper copies of the transcripts (Lofland et al. 2006; Charmaz 2006; Charmaz 1996; Charmaz and Mitchell 2001; Seale 1999; Warren and Karner 2010). I open coded in vivo, by using participants' words rather than coding by pre-identified themes, in order to remain "close to the data," open to interpretation of participants' words, and to allow for an inductive analysis of the data (Charmaz 2006; Charmaz and Mitchell 2001; Glaser and Strauss 1999[1967]; Seale 1999). I also strove to open code interview using gerunds, or verbs ending in -ing, so that I was better able to identify the processes that participants engaged in while using herbal medicine (Charmaz 2006).

Open coding helped to identify and categorize data into categorical and thematic codes. I developed categorical codes to define and broadly organize participants' experiences, beliefs, and other thoughts, and thematic codes to reflect emergent themes within these categories. I dissected all interview text by excerpting passages into Word documents that fit each categorical code. As I began focused coding (Lofland et al. 2006:201-209), I identified three broad categorical codes that were related to why and how participants first started using herbal medicine: the story category that included all passages where participants discussed how and why they began using herbal medicine and which grew to encompass the evolve category that included all passages where participants discussed how and why they continued to use herbal medicine following their initial use; and the dissatisfaction with Western medicine category that

contained all passages that referred to participants' experiences and views with Western medicine. Other categorical codes that did not reflect data that helped to answer the question of why and how participants chose to begin using herbal medicine were set aside for future analysis in future work, such as in understanding how participants continued to use herbal medicine, the process by which some herbal medicine users became professional herbalists, and the meaning that the practice of herbalism has for participants in everyday life (see Appendix L for a list of categorical and thematic codes uncovered in this analysis).

I coded the content in the story and evolve category codes using highlighters, markers, and pens on paper copies of these narrative excerpts. In line with thematic narrative analysis (Riessman 2000; Riessman 2012), I kept accounts of each participants' story of their initial and continued use of herbal medicine intact so that I could ascertain the sequential ordering of influences identified by each participant. I dissected excerpts from the dissatisfaction with Western medicine category into different Word documents according to themes, and then further distinguished sub-themes by dividing excerpts into different sections of each Word document.

I engaged in the process of constant comparative coding (Glaser and Strauss 1999[1967]:105-113), by which I compared the content in thematic codes across participants and within thematic codes. This was accomplished by way of developing multiple tables, diagrams, and outlines that mapped and refined thematic codes. In so doing, I was better able to detect degrees of overlap and difference in participants' experiences, influences, and beliefs identified by the same thematic code. As I continued the process of constant comparative coding, I more carefully compared the content of each theme with the refined conceptualization of that thematic category. Through this process I was able to better discern nuances in the data that were, in part, both particular to and partially overlapped with individual participants' experiences and influences.

I wrote memos with regard to the content that comprised codes, how I distinguished between codes, emergent patterns and nuances in code categories, and the relationship of emergent themes with existing research and included them in my running log of field notes (see above discussion of field notes) (Charmaz 2006; Glaser and Strauss 1999[1967]; Lofland et al. 2006). Memo writing alongside constant comparative analysis allowed me to simultaneously engage in the process of validity checking, such as by considering the goodness of fit between data, code categories, and existent literature (Cho and Trent 2006; Seale 1999; Warren and Karner 2010). I considered alternative ways of organizing and patterning the relationships among thematic codes so as to improve the vigor and validity of this analysis. When no negative cases were found in the data, I referred to previous research and engaged in informal conversations with other herbal medicine users whom I was in personal contact with to further validate my interpretation and analysis of the data (Seale 1999). As I neared the end of data analysis, I further refined thematic and sub-thematic code categories and engaged in a more intensive, focused review of extant literature relating to themes that emerged through the analysis. Finally, I drafted the findings of this analysis, to which I turn to in the next chapter.

CONCLUSION

In order to understand how people begin using herbal medicine, I performed 28 face-to-face in-depth intensive interviews with current, regular herbal medicine users in Cincinnati, Ohio (n=14) and St. Louis, Missouri (n=28) from June 2013-June 2015. Interviews were guided by an interview guide, audio-recorded, transcribed, and thematically analyzed. I also observed and participated in the process of using herbal medicine, and documented this process in field notes and photographs. I wrote memos about the research process throughout the process of collecting data, analyzing data, and drafting this manuscript. Consistent with the constructivist-interpretive

paradigm in qualitative research, these methods allowed me to interpret how participants experienced the process of beginning to use herbal medicine.

Chapter 3: Cultivating an Interest in Herbal Medicine Use

INTRODUCTION

Participants identified numerous beliefs, attitudes, social and cultural influences, experiences with nature and herbal medicine, and situational conditions that they experienced in different combinations and sequences in the process of starting to regularly use herbal medicine. In brief, 7 (25%) participants began using herbal medicine out of a general interest in its use, 9 (32%) participants began using herbal medicine solely in response to a situational condition, and 12 (43%) participants had a pre-existing interest in herbal medicine that influenced their choice to use when they were prompted by situational condition (see Table 3.1 below for a summary of key influences upon participants' choice to begin using herbal medicine). I found two principle starting points for participants' path to using herbal medicine: an interest in its use and experiencing an illness or injury.

A valuation of nature and awareness of and respect for the medicinal use of plants cultivated by social and cultural influences and experiences with the natural world, herbal medicine, and CAM therapies during childhood and early adulthood led 19 (67%) participants to develop an interest in herbal medicine. This interest alongside varying degrees of experiential knowledge about the use of herbal medicine and concerns about the use of pharmaceutical medicine set the stage for these participants to seek herbal medicine to maintain their health, prevent the use of Western medicine, and to treat emergent health needs.

Twenty-one (75%) participants believed that herbal medicine was safer, more effective, more accessible, or a better fit than Western medicine to treat emergent health needs and/or maintain their health in an effort to prevent the use of Western medicine. Participants developed and/or

drew upon these beliefs during experiences with chronic illness, injuries, pregnancy, and a lack of health insurance. Over ½ of the participants who experienced a situational condition, predominately participants who began using herbal medicine while pregnant or without health insurance, had a pre-existing interest in herbalism. Many participants who began using herbal medicine to treat an illness did not indicate having an interest in herbal medicine prior to becoming ill and developing dissatisfaction with the Western medical approach to their illness.

While participants indicated embarking on the path to regularly using herbal medicine at different points, all participants indicated that at some point they became interested in herbal medicine, learned about herbal medicine, and began using herbal medicine. Upon finding herbal medicine effective for its intended purpose, participants' interest in and knowledge seeking about herbal medicine grew, which led to their regular use of herbal medicine.

The following describes how many participants cultivated an interest in herbal medicine throughout the life course and begins as many participants' stories of their initial use of herbal medicine began, with a discussion of how childhood experiences in the natural world and their family's use of herbal medicine cultivated a connection with nature and awareness of and respect for the use of plants for food and medicine. Then I discuss how an interest in and experience with other CAM therapies during early adulthood led some participants to become interested in and learn more about herbal medicine. After that I describe how many participants were further influenced by peers, texts, sub-cultures associated with social movements and geographical locations, and work experiences related to herbal medicine, including work on farms and in health food and herb stores. This chapter ends with a summary of how these influences accumulated throughout participants' life course to draw them into using herbal medicine.

Table 3.1: Broad Influences on the Choice to Begin Using Herbal Medicine
(See Appendix M for tables that detail each of these influences.)

Participant Name	Broad Influences on Beginning Herbal Medicine Use				
	Childhood	Adulthood	Situational Conditions	Dissatisfaction with Western Medicine	Pharmaceutical Concerns
Maggie	X	X	P		X
Theresa		S	I; H	X*	X
Carol		S	H	X	X
Bob	X	X	H	X	X
Andrea	X, C	X	P		X
Morgan		S	H	X	X
Lilly	X	S	I	X*	X
Tom	X	S	H	X	X
Tara	X	S	P		X
Jessica	X	X	P		X
Alaina	C	X			
Tory	C	X	H	X	X
Zoe		S	H	X*	X
Jody	X, C	X			X
Angie	X	X			X
Eileen		S	H	X	X
Jeanette		S	H	X	X
Molly	X	X	P		X
Allen		S	H	X	X
Betty	C	X			X
Monica	X	X			X
Alisha	C	S	I	X*	X
Glen		S	H	X	X
Mary		S	H	X	X
Steven	X	X	H	X	X
Denise	C	X			X
Joan	X	X			X
Amanda	X	X	P		X

C=CAM/natural health interest in late childhood/early adulthood

S=Sought or encountered information from people or texts during situational circumstance

P=pregnancy; I=lack of health insurance; H=illness or injury

* Indicates belief that Western medicine was inaccessible

FINDINGS

Childhood Experiences and Influences

Participants indicated a wide diversity of influences and experiences that accumulated throughout their life course and cultivated an interest in herbal medicine. Experiences with nature, particularly during childhood, cultivated a connection to and valuation of nature that led an interest in learning more about the use of plants for food and medicine. Experiences with herbal medicine stemming from participants' families' use of herbal medicine during childhood cultivated an awareness of the medicinal potential of plants alongside experiential knowledge of how to use particular plants for specific ailments. By extension, participants' awareness of their family's historical use of herbal medicine, such as by midwives and Native American ancestors, cultivated an interest and respect for the medical and spiritual use of herbal medicine. In addition to the 14 (50%) participants who indicated childhood experiences and influences that cultivated their interest in herbal medicine, 5 (18%) additional participants indicated an emergent interest in natural health and other CAM modalities during early adulthood, which by extension led to an interest in the use of herbal medicine.

Developing a connection with plants

Some participants recounted childhood experiences with nature and plants, including spending a lot of time outside playing in backyards and adjacent wooded areas, having a family garden, experimenting with edible and medicinal plants with other children during play, and, in one case, imagining play in wooded areas. These formative experiences cultivated a connection with nature that participants often identified as part of who they are, where a valuation of nature

became part of their self-concept. Some participants described how they were “always” outside as children or, as described by Lilly, “always... a nature girl tree hugger.”

My siblings are older than I am, so I was alone a lot... I was always in the woods gathering berries or being in the woods and the trees and just sitting there and that I think has something to do with an introduction or connection. (Tara)

I always spent a lot of time outside as a kid and my parents are gardeners. So we've always grown our own food, and that was my most basic connection to start working with plants. ... So I think really just spending the majority of my life outside has really just kind of cultivated this innate sense of, this is where I should be and these are the relationships that I should be cultivating. (Joan)

I always wanted to be outside, climbing trees and running around and looking at animals. And, you know, people when I was a little kid probably thought that I was going to grow up to be a wildlife biologist or something because I love animals, but the plants really became more fascinating to me as I got older. (Monica)

Participants additionally noted specific instances when they incorporated edible and medicinal plants in their play with other children. As recounted by Bob:

[There was a] little neighbor girl who showed me a plant that was used as a medicine. And I just never forgot that; it's a real vivid memory. And I don't remember if I had a burn or poison ivy or something like that, but she showed me, it was a succulent, a type of sedum, and she just rubbed it on my arm. She said, 'it's soothing,' or something... But I don't think we knew what we were doing, we just did that as kids. So I guess that's my early experience with plants.

And, while Angie explained that while she didn't physically spend a lot of time in nature growing up, she described how imagining herself in nature was important in forming a connection with the natural world:

I think I've always been in some sort of a sense, weirdly connected, like drawn to nature even though I don't spend a lot of time in it. Like, my happy place when I as little was always this dark green forest that was impenetrable by anything else except for, like, the cute little animals.

It is likely that many, if not all, participants value nature and could recount impressionable childhood experiences with nature that contributed to their beliefs and attitudes about nature and the environment if pressed to do so. Participants' accounts of childhood experiences with nature as part of the story of how they first started using herbal medicine described here illustrates how childhood experiences in nature constituted the first step in cultivating a connection with nature that would inform their valuation of nature as part of their self-concept, which in turn would later inform their interest in herbal medicine.

Family influence

Some participants also described how their family's use of herbal medicine while growing up cultivated an awareness of and respect for the edible and medicinal use of plants. Childhood experiences with their family's use of herbal medicine ranged from their parents' use of herbal medicine on them as children, a practice that oftentimes stemmed from their grandparents' use of herbal medicine and functioned to expose participants to experiential knowledge of its use, to referencing a respect for grandparents who used herbal medicine that transferred into participants' respect for the use of plants for medicine, particularly when participants' grandparents were practicing midwives. Some participants also drew upon a sense of respect for their ancestors' traditional use of herbal medicine, such as by Native Americans and "mountain people," when discussing how they became interested in the use of herbal medicine.

For example, Monica, Tom, and Amanda described how they learned about the use of herbal medicine from their parents, whereby Monica's parents learned the use of herbal medicine from her grandparents:

I was exposed to it [herbalism] pretty young in a sense because, I mentioned my father was from Austria. So he had a grandmother who lived way up in the mountains and he would go spend the summer with her. And she lived very close to the land, and he grew up using arnica and chamomile, and herbs like that. Elderberry was a big one in the family as well. And so when I was a little girl and I used to get a tummy ache, he would give me chamomile. So that was kind of my first exposure to it. But, honestly, I didn't think much about it until I was about 18.

My father, when I was younger, I remember him giving us herbs, talking about herbs. And he ... was always one to take care of himself. And he had some philosophies that I guess he found from his grandmother and living and the farm and that. ... So I remember that at a young age.

I remember my mom used to give me and my brother Echinacea and vitamin C, which I thought was really, I mean, you know at the time I did not think anything of it because it was mom... But I guess when I really started getting into my own use of herbs I was influenced by my mom... I guess I was kind of curious about that magical herb my mom used to always shove down our throats (laughs).

Some of the participants who were influenced by their family's use of plants growing up indicated that they didn't think about their family's use of medicinal plants much growing up, or as expressed by Jessica, "when you're a child, you don't listen to such things." Instead, these childhood influences and experiences set the stage for them to become interested in and seek and be receptive to additional influences and experiences later in life. Steven and Andrea additionally described the influence of their grandmothers' professional use of herbs in midwifery upon their parents and themselves as children on cultivating a respect for herbal medicine. Interestingly, both participants also described their valuation of a book containing their grandmothers' knowledge of herbal medicine:

My grandmother was born just after the Civil War and eventually became a midwife. I remember her sitting in her living room with a very large book on her lap. She called this book her doctor book. As a child she came to my aid many times with poultices and ointments that she had made in her kitchen. Having said this, I grew up believing in herbal medicine. I still have her book.

My grandmother was an herbalist midwife in Appalachia, a mother of 16. My mother was the last. And this was not a chosen profession, this was survival. ... And so it's what she learned. And there's so much of what she knew, that's gone because, sadly, she did have a book but my aunt who is very religious saw that book, instead of it being this wonderful thing, as being the word of satan. I don't want to use that word but you understand where I'm going with that. She didn't put value in that book, so that book got lost or thrown away or whatever. My mother being the baby, she would remember just a little bit, and I've got some notes from talking to my mother. Things like, I think it was the bloodroot for fleas on dogs, and just things like that that her mother would do and that my mom remembers. ... So I see her [my grandmother] as just being such a strong woman. ... She was kind of my inspiration for all this.

Jessica and Jody also described fond memories of their grandparents' connection with nature and common knowledge of how to use plants medicinally. These memories resonated with them as they sought and were exposed to additional influences experiences during their adulthood, upon which these memories functioned to fuel their respect for the use of herbal medicine:

My grandmother braided her rugs, did all the canning, never wore anything but a dress. And any time that I get poison ivy I still look for jewel weed in the woods because everything in nature has an opposite, and jewel weed will cure poison ivy. All of this was common knowledge to them... I had wonderful grandparents and I associated that [the back to earth component of the hippie movement] with them because they were so knowledgeable and I thought, this is just them in a different light. And then I really started respecting my grandparents for their knowledge more.

I've always loved herbs. I love how they smell, how they look. ... And just seeing pictures and reading, and then going back, remembering flowers my grandma grew and herbs. So I started reading herb magazines and getting herb books and reading more and more about herbs.

Participants often referred to their grandparents' knowledge of how to use herbal medicine as a commonsense and practical knowledge that we have lost in recent generations. Echoing Andrea's lamenting of the loss of her grandmother's book on how to use herbal medicine in

midwifery, Tory described her regret for not learning more of this knowledge from her grandmother:

My grandmother was the last generation to know about health and food, and my mother was born in 1910, so that's how many years ago my grandmother would have been active. And it was pretty common when you had something wrong with you that they would just go outside and pick something and make tea. And I regret that I didn't learn about that, you know, because I think they were things that were just common sense, that people just knew that you did.

More often than not, participants who cited the influence of their family's use of herbal medicine upon their respect for and knowledge of use of plants for medicine did not recognize the impact of these influences upon their interest in herbal medicine until later in life. Once these participants developed an interest in learning how to use herbal medicine later in life, they grew to increasingly value the experiential knowledge of herbal medicine use passed down through the generations and, in some cases, lamented the loss of this knowledge throughout the years.

Traditional use of herbal medicine

Four of the participants who had childhood experiences in nature and were exposed to herbal medicine growing up additionally drew upon their Native American ancestors' traditional use of herbal medicine use as an influence upon their awareness of and respect for the use of plants for medicine. For instance both Joan and Monica described how the knowledge of their ancestors' traditional use of herbal medicine informed their desire to unearth and revive this cultural legacy of herbal medicine:

I'm part Cherokee, and that hasn't been talked a lot about in my family. So both my dad and I have connected over researching more into our roots, and our culture, and our heritage. And that also let me to be interested in the natural and traditional uses of plants more than just like as a food.

I feel like that desire to be a part of nature and to have a hand in it and shape it and be close to it, is really in all of us already. I think that we're born with it. And then, you know, I come from, on my mom's side of the family there's Scottish and Cherokee, and then on my dad's side is Mountain people. So, I really think too that I come from cultures with really strong herbal traditions. So maybe that makes it a little bit stronger in me.

Participants who described the influence of their ancestors' traditional use of herbal medicine often focused on how these traditional practices were maintained among their immediate family, and consequently themselves, while Monica additionally described how "an interest in it [herbalism] was probably even a little bit programmed into who I am as a human being." In contrast to the passing down of knowledge of their ancestors' traditional use of herbal medicine, Joan referred to actively researching and learning more about her cultural history. That is, instead of being exposed to Cherokee cultural traditions as a child, Joan and her father actively unearthed and resuscitated their cultural heritage of herbal medicine use.

The influence of knowledge that Native Americans used plants for medicine without mention of Native American ancestry also cultivated a sense of respect for and interest in the use of herbal medicine. As described by Mary,

I don't recall any particular person that played a big influence in my life, it was mostly my own and just wanting that knowledge [about herbs as medicine]. I wanted to learn because it really intrigued me. And, again, I think too, the whole Native American, because obviously they were using them long before anybody else. And so it was just learning about that [herbs as medicine] from that perspective.

Rather than exert a direct influence upon participants' choice to use herbal medicine, these early experiences and influences cultivated a connection with the natural world, an awareness and respect for the medicinal uses of plants, and an interest in and desire to learn more about the use

of plants for medicine, which in turn set the stage for half of the participants in this research to begin using herbal medicine.

Interest in CAM

Interests in other CAM modalities and natural health that exerted a large influence on participants' desire to learn more about the use of herbal medicine spanned mind-body approaches to health, homeopathy, acupuncture, gardening, and local foods. Seven (25%) participants, five of whom did not indicate influential childhood experiences or their family's use of herbal medicine growing up, described how an emergent interest in CAM and natural health during early adulthood led to an interest in the use of herbal medicine and the desire to learn more about its use, such as from texts, CAM practitioners, and peers. For instance, Betty noted how "in the back of my mind, I've always been curious of alternative therapies in general, you know. I've always been interested in acupuncture and Qigong and things like that." And, while Andrea was exposed to herbal medicine during her childhood, she cited how she actively sought information on the use of plant medicine following an emergent interest in CAM as a teenager:

When I was 16 is when I first became interested in the power of the mind over the body. ... ESP, finding out at that time that it was still something that they were going to research, you know, so I was like, wow, this has a scientific component to it, this is a real thing. ... That just really fascinated me, and it was that that kind of led, again the mind-body and that connection, into healing practices using the mind to heal. And then, it's like using safe plants, what's been used over millennia for healing. And so I got more and more interested in that.

Denise described how when she was a young adult she was interested in natural health and tried different dietary supplements. In line with her interest in natural health and Chinese culture and traditional medicine, she eventually met an influential CAM practitioner and pursued schooling for acupuncture where she was taught how to use herbal medicine, which then led her to pursue the practice of herbal medicine.

First I started off, I was going to go into Indian medicine, and then just the way life works I met an acupuncturist and she inspired me. And then I ended up going to school for acupuncture. I actually at that point did not really put that much thought into the herbs, but the acupuncture program involves an herbal program. So just my level of awareness and what I do daily totally changed from there.

In addition to an interest in energy healing, Alisha was additionally influenced by her experience with a holistic medical doctor while living in Wisconsin. The doctor “did diagnosing with a pendulum, which was absolutely fascinating.” Alisha also recalled a later experience with an integrative doctor, where “he actually had me go on a five day liver cleanse [where] I would actually decoct the herbs and then drink the liquid everyday” as a big influence on her choice to start using herbal medicine. As a young mother, Tory sought care from a homeopathic physician to treat her son’s asthma, who taught her how to use homeopathic remedies: “He [the homeopathic physician] told me, he was 90 at the time, a frail little old man, and he told me he would be dead before I raise this child, and that he wanted to teach me what to do because he was really serious about asthma.” In hindsight, Tory recounts how “there weren’t a lot of people” that she learned from, but “what I learned from that original homeopathic doctor was major.” In these cases, an interest in other CAM therapies and positive experiences with CAM practitioners led participants to become interested in learning how to use herbal medicine.

An interest in natural health and gardening also led participants to become interested in the use of herbal medicine. Alaina described how her interest in local foods and natural health led her to meet a friend who became a large influence on her personal use of herbal medicine.

We got to know them because we met them in a [farmer’s] market and we were buying their produce, and became very interested in getting to know them because they were right in our town. It was like, whoa, that’s awesome, that’s the kind of food we’re eating. We were already interested in local foods. So that was very much natural for me because I feel like the way in which I practice herbalism ...

is very much about nourishment. And I've always been interested in nourishment for the sake of my own health and my family's health.

Nearly all participants indicated some affinity for gardening, and a few indicated a desire to garden more. However, when it came to participants for whom their passion for gardening heavily influenced their choice to start using herbal medicine, Jody described how she “just started out wanting to be a gardener,” “I always knew there was a gardener in me. I just wanted to dig in the earth. I'm an artist, and I have a pottery wheel downstairs, I've done watercolors, pencil drawing, but to me, the earth is my canvas. I could just always feel it inside of me.”

In summary, 2/3 of the participants in this research indicated that their interest in herbal medicine was rooted in their sense of a connection with nature stemming from childhood experiences in nature; an awareness of and respect for herbal medicine stemming from their family's use of herbal medicine growing up and knowledge of their ancestors' traditional use of plants for medicine; and an emergent interest in other CAM therapies, natural health, and gardening during early adulthood. While these influences and experiences were largely taken-for-granted as just part of who they are or how they were raised, they ultimately functioned to cultivate an interest in the use of herbal medicine and a desire to acquire more knowledge about its use. Many of these participants' emergent interest in herbal medicine led them to actively seek or be receptive to yet more influences on their choice to begin using herbal medicine later in life, including the influence of sub-cultures associated with social movements and geographical locations, texts, peers, and experience working on farms and in health food and herb stores.

Sub-Cultures, Texts, and Peer Influence

Many participants who developed an interest in herbal medicine throughout their youth continued to accumulate more knowledge and develop a deeper interest in the use of herbal

medicine during adulthood. These influences included people such as peers, their partners, and CAM practitioners; sub-cultures associated with social movements (including the 1960-1970s Hippie Movement and the more recent Occupy Movement) and bound to geographic locations; and herbal and gardening texts. The influence of social movements was often bound to influential texts and peers. For instance, Angie described how her participation in the Occupy Movement led her to meet new friends who influenced her to seek more knowledge about the use of herbal medicine:

When I went to Occupy, I met with a lot of people there who shaped what I thought and what I wanted to get involved with. One of my friends was a tarot reader and a psychic, and she's really into the occult kind of different things. And so as I started researching that, I also started researching herbs. And I read a lot of gardeners who are also into herbs. And so I got really excited about wanting to research that. And then I went to my friend's bookstore ... and I found this book called *The Way of Herbs* ... And for a long time, all I was doing was reading that book and transcribing it.

And Jessica described how her participation in 1960-70's hippie movement cultivated a respect for others involved in this movement and an interest in the use of herbal medicine that solidified upon reading a book that was widely referenced in this sub-culture. As recounted by Jessica:

I think it was from being in college in the 70s, and the book *Back to Eden* was in the bookstore. And it was the hippie movement, and naturally I was in the thick of that, umm hmm, big time. ... And I thought, wow, this book is so informative, and I've used it ever since. ... It was just how so many people that were getting their Masters and Doctorates, how they would like eat sprouts and all these things, and that was their nutrition. And that impressed me so much. ... And I wanted to be part of that movement.

Instead of seeking information about the use of herbal medicine after meeting influential people involved in a social movement, Molly explained how her father-in-law taught her about herbal medicine, which, following her involvement in the hippie movement in California and becoming pregnant, led her to seek more information about herbal medicine from texts:

My father-in-law took an interest in me because I wanted to know. I would go in the health food store with him when he went in ... The fact that my father-in-law was showing me so much interest made me as a young person to want to know more about what he was doing. ... And then my husband and I at that time hitchhiked to Los Angeles. We were hippies, and living in Los Angeles in 1968, it was very alternative, lots of natural foods. And I just kept up my interest and just kept learning more.

In these cases, childhood influences and experiences combined with the influence of sub-cultures associated with social movements and peers associated with these sub-cultures led these participants to actively seek information about the use of herbal medicine from texts. In addition, simply living in a place where herbal medicine and CAM is popular, often in combination with a pre-existing interest in herbal medicine and the influence of people and texts, led some participants to become interested in learning more about herbal medicine. As discussed above, Alisha's interest in herbalism stemmed from an interest in CAM that she developed while living in the Madison, Wisconsin area, where "they have much more of a consciousness about this kind of thing," leading her to be "exposed early on." And, Zoe described how when she was 25, she moved to a college town in New York that was "known to be kind of hippy dippy, new agey" and "started to meet people who are massage therapists and people who used herbs." Thus, the availability of herbal medicine and knowledge about its use within sub-cultures associated with social movements and geographic locations alongside the more direct influence of people and texts encountered in these sub-cultures further influenced participants who were receptive to these ideas to learn more about herbal medicine.

Without mention to involvement in a CAM- or herbal-friendly sub-culture, several participants described how peers and texts independently contributed to their interest in using herbal medicine. For instance, Alaina indicated getting involved in herbal medicine "very much through the influence of my friend, Tara, and observing what she was doing and really finding an

instant connection with an aspect of myself that I didn't even know what there before." And Tara described the influence of her partner in college, who "used to work with herbs, just an interest, a hobby of his own. So we would talk about different plants or different books."

The influence of peers was especially salient among participants who indicated the medicinal use of *Cannabis*. While *Cannabis* is still an illicit herbal medicine in many states and on the federal level, all participants recognized varying degrees of the medicinal potential of this plant, and many believed it should not be illegal. While a few participants noted their use of this plant as a medicine, Amanda and Bob described how learning how to use this plant recreationally from peers as teenagers influenced them to use it and other plants as medicine later in their lives. For instance, Amanda described how she and the father of her first child "would make our own wine and grow marijuana that we used to bring to festivals. And again, I guess that wasn't really about the medicinal aspect as it was that we were teenagers wanting to get high. But I just loved the idea of making all of that stuff, I kind of enjoyed it." While Amanda's experience growing and producing *Cannabis* and wine for consumption led her to develop an interest in making natural products, Bob's early recreational experiences with this plant cultivated a respect for the psychoactive effects of medicinal plants that would inform his choice to use medicinal plants following a car accident several years later.

This finding reflects how *Cannabis* users, and perhaps all medicinal plant users, must learn how to use the plant objectively (e.g., how to process and consume the plant material) and subjectively (e.g., learn how to experience the desired effects of using the plant) (Becker 1953). The majority of first-time *Cannabis* users must learn how to prepare the plant for consumption and its intended effects, and most new users do not report feeling 'high' the first time they use *Cannabis*--this is something that is learned while using the medicinal plant with others (Becker

1953; Hirsch, Conforti and Graney 1990). Likewise, herbal medicine users must learn how to prepare the plant for consumption as well as how to recognize the therapeutic effects of herbal medicine. These initial experiences by which Amanda and Bob learned how to use *Cannabis* for recreational purposes informed their learning how to use the plant for medicinal purposes later in life.

While all participants indicated referring to texts to learn how to use herbal medicine at some point in their lifetime, the influence of learning from texts was cited as a particularly salient influence upon some participants' choice to start using herbal medicine. As described above, Jessica cited her reading of *Back to Eden*, and Angie her reading of *The Way of Herbs* in tandem with the influence of social movements as very influential in their use of herbal medicine. In addition, Joan described how after developing a connection to the natural world during her childhood and studying environmental biology in college, she...

realized that it was a more organic connection for me to just be around the plants, growing the plants, and then realizing and learning more about their medicinal properties, because I wasn't familiar with any of that until I picked up a book one day. And I was just reading through it and it was the *20,000 Secrets of Tea*, and it listed all these plants and their medicinal properties. ... In the beginning, I had this intense excitement and just vigor to learn all this information. And I'm totally a bookworm, so I would just go and check out all these books and then read a lot of information. And that's how it started for me.

Jody, a passionate gardener, also cited the salient influence of gardening texts upon her choice to begin using herbal medicine:

Probably the most influential thing in my life was..., about 2002 I got a catalogue from Baker Creek, okay, and I love those people. I started reading about Frankenfoods, GMOs, Monsanto, the difference between heirloom and hybrid, and it was an eye-opener for me. I must've bought every seed that guy sold and tried to plant them all. And it just kind of all snowballed from there because I've always loved herbs, I love how they smell, how they look. ... So I started

reading herb magazines and getting herb books and reading more about herbs. I can't explain it, it just became a passion, it just snowballed.

All participants who indicated that influence of texts was especially salient upon their choice to use herbal medicine described how they sought texts for information about the use of herbal medicine in line with their emergent interest in its use cultivated by other experiences and influences throughout the life course. As they learned more about the use of herbal medicine, they became more interested in learning yet more about how to use herbal medicine. This finding suggests learning about herbal medicine is an important pre-requisite for the practice of herbalism. Further, the vast majority of influential texts cited by participants were in the form of books authored by professional herbalists. It's important to note that no participants indicated that they initially learned how to use herbal medicine in direct consultation with a professional herbalist. Instead, participants indicated initially learning indirectly from professional herbalists by reading their texts.

Participants who turned to herbal medicine as a result of experiences and influences throughout their life course also commonly referred to their personal love for reading. For instance, Joan described herself as a "bookworm" and Lilly as an "avid reader." Interestingly, those who turned to herbal medicine to treat an emergent health need (discussed in chapter 4) referred primarily to their research skills. This difference in participants' framing of their desire to learn more about herbal medicine is likely because participants who began using herbal medicine prior to experiencing illnesses developed an interest in their use that led them to learn more about plants and herbal medicine in general, while participants who started using herbal medicine to treat a particular health condition drew primarily upon their skills as a researcher to learn about the use of herbal medicine to treat their specific condition.

Work Experiences

Some participants' valuation of nature and interest in herbal medicine gradually led them to seek more (and/or be open to) experiences working with medicinal plants during adulthood, including work on farms and in health food and herb stores where herbal medicine was grown, processed, and sold. In turn, these experiences working with medicinal plants alongside knowledgeable co-workers and customers imparted experiential knowledge about the use of herbal medicine that in turn informed their use of herbal medicine. For instance, Alaina describes how after meeting an influential friend by way of her interest in local foods, she experienced how to grow, process, and use herbal medicine by volunteering at her farm:

When I first met her, I was going to help work on the farm, and she had what she refers to as her healing herb bed and she had motherwort growing in there. And I was a mom with an infant and we actually worked with the motherwort to make tincture together, and she showed me the process of that. And in addition I was in the herb bed with her, helping her cultivate and attend to it, and then harvest the motherwort. And so then I started using motherwort and that was an awakening experience, or transformation like you ask, because it was through the use of that plant that I really awakened to the idea of, wow, this can really benefit me.

Likewise, Maggie also described how her interest in nature led her to move to the West coast and work on a farm where she developed a connection with plants. After working on the farm for several years, she lived with a neighboring Native American family who taught her about the medicinal use of plants:

I can probably say I first really got into it when I moved out west and stayed in kind of an apprenticeship on a farm... And so I began my real connection with plants and with the whole cycle of growing. ... So that was just like this big opening, moving out, being independent, seeing different ways of life and growing food. And, so right down the street from there was this Native American family who I ended up living with when I moved off the farm, and they really gave me this great spiritual connection to plants, and really just having gratitude

and seeing them as another living being, you know, and as a medicine... And so I got to learn about that. And they would use plants medicinally here and there, so I think that was really my first kind of mentorship with plants and herbs.

In addition to hands on work on farms where edible and medicinal plants were grown and consumed, some participants also described how their interest in herbal medicine stemming from childhood influences and experiences led them to work at health food and herb stores. As described by all participants who worked in health food and herb stores at some point in their life, this experience was profoundly educational because they had to learn how to use herbal medicine in order to guide customers' to appropriate products. As explained by Monica, in so doing, they also learned how to use herbal medicine for their self.

So I was interested in it [herbalism] but wasn't thinking that much about it, you know. ... But then, when I was 18, I had a friend who had a job in a health food store, and I had just come back from my first year of college and I was trying to find work and she was like, 'well, we're hiring, you should come in.' So I did... I started working there and people would come in there and have problems... and I wanted to help them, you know. And we had all these books and stuff like that there. So I started off just looking up things in the book for them, and it got to the point that I didn't need to look it up anymore, I knew what the book said. ... So I started just kind of learning that way and then I started collecting the books... I didn't really work there that long, but that was definitely the start for me being really interested in herbs.

In addition to learning about herbal medicine by way of guiding herbal product consumers, Steven described learning from customers by listening to their experiences with herbal products:

You learn so much from the people that you talk to, not just from what you read and what you see on labels, but the people actually come in and give you lessons on what works and what doesn't work. You just have to listen to what they're saying, you know. And sometimes you have to fix it, sometimes they might be a little off center. But that's where I picked up so much is just by listening to what people do.

In this way, a pre-existing interest in the use of plants for medicine cultivated through social and cultural influences and experiences throughout these participants' life course led them to seek

and/or be receptive to information during adulthood, such as from peers and texts, some of which were associated with sub-cultures bound to social movements and geographic locations, and CAM providers. Some participants also referred to seeking and/or being open to experiential knowledge about the use of herbal medicine. Not unlike the influence of social movements, this experiential knowledge was not learned in isolation from others; rather, participants indicated learning from texts and co-workers and clients in the workplace alongside the practice of growing, harvesting, processing, and selecting plants for use as medicine.

CONCLUSION

Many participants in this research first developed an interest in the use of herbal medicine that largely stemmed from their connection with nature, an awareness of and respect for the use of plants for medicine, and an interest in other CAM therapies, natural health, and gardening. Experiences playing in nature as a child cultivated a connection with nature that led some participants to value nature, which in turn led to an interest in the edible and medicinal use of plants. Some participants also indicated that their family's use of herbal medicine, both during participants' childhood and historically in the traditional midwife and Native American herbal traditions, cultivated an awareness of and respect for the use of plants as medicine and conveyed varying degrees of experiential knowledge of how to use plants for medicine. And, a few participants indicated that their interest in herbal medicine initially grew out of an emergent interest in and/or experience with CAM, natural health, and gardening in early adulthood that led them to become interested in herbal medicine. Rather than exerting a direct influence upon participants' choice to use herbal medicine, many participants indicated that they did not think much about the impact of these influences and experiences during their youth. Instead, participants' accounts suggest that their valuation of nature, awareness of and respect for the use

of plants for medicine, and an interest in CAM cultivated an interest in the use of herbal medicine.

This interest in herbal medicine, oftentimes in concert with varying degrees of knowledge about its use, led many participants to seek and/or be open to more knowledge about its use by way of additional influences and experiences with herbal medicine throughout adulthood. Some participants indicated the influence of sub-cultures associated with social movements and geographical locations, wherein they learned about the use of herbal medicine from peers and texts associated with the sub-culture. The influence of texts and peers was especially salient for a handful of participants, whereby learning about herbal medicine from these sources piqued their interest in learning more about using herbal medicine. Some participants also indicated very influential experiences working on farms where medicinal plants were grown and processed and in health food and herb stores where herbal products were sold. The influence of peers were especially salient during these workplace experiences, whereby co-workers and customers imparted knowledge about how to grow, process, and use herbal medicine for specific indications.

While the relative salience of each of these social and cultural influences and experiences throughout the life course upon participants' choice to begin using herbal medicine was often difficult for participants to identify, some participants were able to discern their primary reason for (or most important influence on) beginning to use herbal medicine. For instance, Maggie and Monica recounted how their experience working in health food stores "was the big thing that got me into it" (Maggie) and "definitely the start of me being really interested in herbs." (Monica). And Jessica and Jody described how reading texts "really started sparking my interest" (Jessica)

and “was probably the most influential thing in my life” (Jody) with regard to making the choice to use herbal medicine.

Of all the influences and experiences described by participants who developed an interest in herbal medicine throughout the life course, the influence of texts, work experiences, CAM practitioners, and peers were most often cited as the most important upon their choice to use herbal medicine, particularly among the quarter of participants who pursued the regular use of herbal medicine independent of its use in response to a situational condition. On the other hand, only a few participants identified social movements and childhood influences and experiences as particularly important influences.

These findings suggest that actively learning about herbal medicine by way of reading texts, talking to others who are knowledgeable about herbal medicine, and participating in some aspect of the practice of herbal medicine is a very important step in making the choice to use herbal medicine. Further, these findings suggest that many participants’ desire to learn how to use herbal medicine use was fueled by an interest in and experiences with herbal medicine throughout childhood and early adulthood. This suggests that while an interest in herbal medicine may motivate one to seek general information about its use, an interest may also be cultivated by way of being exposed to and engaging in practices related to herbal medicine. The finding that many participants did not indicate that social and cultural influences and experiences with nature were particularly influential on their choice to begin using herbal medicine suggests that their emergent interest in herbal medicine was largely taken-for-granted as part of their self-concept or personality.

As will be discussed in chapter 4, participants who had a pre-existing interest in herbal medicine but did not start using herbal medicine until a situation prompted its use indicated that the influences and experiences discussed in this chapter were of secondary importance to the influence of the situational condition. And, most participants who began using herbal medicine to treat an illness developed an interest in its use after developing different forms of dissatisfaction with Western medicine, whereby primacy was also given to the influence of their illness experience and Western medical encounters. In addition, varying degrees of concern with pharmaceuticals, as discussed in chapter 4, additionally exerted varying degrees of influence upon nearly all participants' use of herbal medicine.

These findings indicate that an interest in herbal medicine, sometimes alongside experiential knowledge of its use, led participants to seek more information on how to use herbal medicine, which in turn led to an increased interest in herbal medicine and further information seeking, a process that continued indefinitely throughout the process of using herbal medicine. The dialectical relationship between interest and knowledge (alongside the emergent influence of varying degrees of concern about pharmaceutical medicine as discussed in chapter 4), led a quarter of the participants to begin using herbal medicine. That is, this dialectic of interest and knowledge ultimately culminated into their use of herbal medicine out of a general interest in its use rather than a specific interest in the use of herbal medicine in response to a situational condition. The rest of the participants in this research did not begin regularly using herbal medicine until they encountered a situation that prompted its use in tandem with emergent attitudes and beliefs about herbal and Western medicine.

Chapter 4: Situational Conditions and Dissatisfaction with Western Medicine

INTRODUCTION

Chapter 3 focused on how experiences with nature and medicinal plants and social and cultural influences throughout the life course gradually cultivated an interest in and varying degrees of knowledge about the use of herbal medicine. However, interest in and knowledge about the use of herbal medicine alone led only 7 (25%) participants to actually begin using herbal medicine. The other 21 (75%) participants in this research began regularly using herbal medicine after experiencing an illness, sudden injury, pregnancy, or not having insurance. Participants who began using herbal medicine to treat an emergent health need described how dissatisfaction resulting from Western medicine encounters and concerns about the safety and efficacy of Western medical treatments for their condition influenced their choice to begin using herbal medicine. Participants who experienced a sudden injury or did not have health insurance perceived Western medicine to be inaccessible and/or that herbal medicine was a better fit for treating their ailments. And participants who began regularly using herbal medicine while pregnant did so because they had a pre-existing interest in its use and used it for additional nutrition and/or were concerned about using pharmaceutical medicine during pregnancy and child rearing, whereby herbal medicine was deemed safer and a better fit.

Nearly all participants indicated beliefs and attitudes about pharmaceuticals that influenced their choice to begin, as well as to continue, using herbal medicine. Reflecting widespread Western medical cautions against taking pharmaceuticals while pregnant, participants who began using herbal medicine while pregnant or nursing were especially concerned about the risks of using pharmaceuticals. And, participants who were influenced by social movements and/or vicarious

experiences with Western medicine (i.e., by way of observing others' medical experiences, such as clients at work in medical-related professions) were especially concerned about the overuse of pharmaceuticals.

This chapter will address how participants viewed Western medicine, including sources of dissatisfaction with Western medicine, the perceived inaccessibility of Western medicine, the perception of herbal medicine as safer and a better fit than Western medicine, and concerns about pharmaceutical medicine that influenced participants' choice to begin and continue using herbal medicine. Following this is a discussion of how participants navigated the boundary between Western medicine and herbal medicine, and some of the obstacles they encountered on their path to using herbal medicine

FINDINGS

Sociology of Illness

Illnesses are socially constructed; they are socially assigned negative connotations, differentially experienced by different groups of people across time and space, scientifically named and renamed, considered debilitating (or not) and legitimized (or not) by medical and legal professionals (Conrad and Barker 2010). Illnesses are also "socially produced" by way of interactions between physicians, patients, and others involved in the illness experience (e.g., such as the patient's significant others) in different social contexts (Mishler 1981:166-167). Further, medical diagnoses are not naturally inherent to a symptom cluster; rather, medical diagnoses are names constructed to identify and group illness experiences that reflect objective (e.g., an observable physical abnormality) and subjective (e.g., feeling pain or fatigue) components (Jutel and Nettleton 2011). Medical diagnoses and treatment decisions are negotiated between

physicians and patients to “accomplish the goals of assessing and managing a particular medical problem” (Drass 2008:325). Yet, these negotiations may not always result in doctor and patient agreement about the patient’s diagnosis and treatments. Such is the case in varying forms and to different degrees among many participants who sought Western medical expertise during an illness experience, particularly when it came to participants who encountered a cancer diagnosis or experienced contested illness.

Doctor-Patient Encounters

Some participants decided to start using herbal medicine after judging their initial consultation with a Western medical doctor unfavorably. This desire to seek herbal medicine stemmed from three key attitudes emerging during consultation with their doctors with regard to their ailments: an unwillingness to accept the cancer diagnosis and prognosis as constructed by Western medicine, the perception of poor quality doctor-patient communication, and the perceived inability of their doctor to provide acceptable answers with regard to their condition, prognosis, and treatment options.

Western medical constructions of health and illness

Participants who were either professionally diagnosed or believed to be suffering from cancer accepted their predicament to the point of seeking more information about their condition and different ways to treat it. However, some did not accept their doctor’s construction of the cancer diagnosis insofar as next diagnostic steps were concerned. As explained by Jeanette, “I had the diagnosis from three different doctors who all rudely told me the same way. It was really amazing. Everyone said it the same way, ‘oh, you could have lymphoma, you have to have a biopsy.’” As a new home owner, a business owner, and a single mom raising three children,

Jeanette “was like, alright, I am not going to put my family through this potential diagnosis of cancer yet. I just kind of was like singly focused on, let’s study and find out if it’s cancer. I don’t want to know, I don’t want my children to know.”

On the other hand, Tom was diagnosed with prostate cancer during a routine check-up, and

...it was already at a level where they wanted me to do a radical prostatectomy right away, and I was signed up to do that... I mean, when they tell you that you have cancer, it kind of hits you as a shock, when they say you got to do this right away. And all of a sudden, your impulse is like, you know, what do I want to do, how bad is this? But I started really investigating everything there was out there about it and I started realizing that there were other methods that people were doing. ... and I quit going and even getting a PSA test because all that did was cause me to question my belief. ... I do not see myself with malignancy, I see myself free of malignancies.

While Jeanette did not consent to further diagnostics to confirm whether she did actually have cancer and Tom did not pursue further diagnostics to confirm the progression of his cancer after his doctor first diagnosed him with cancer, both researched and used herbal medicine to treat their condition. It seems that both participants had to set aside the implications of the cancer diagnosis and deal with their illness on their own terms in order to avoid the negative impact of a cancer diagnosis as constructed by Western medicine upon their thinking, and their family’s thinking, about their condition and prognosis.

Allen also sought herbal medicine after Western medicine had difficulty diagnosing his illness and offered little in the way of answers as to how to treat his condition. After going to the Emergency Room only for his symptoms to dissipate and to not receive a diagnosis for his condition, Allen later went to his doctor. According to Allen,

I got to the doctor and the doctor is like, ‘well, this is what you have,’ shrug, kind of thing. And I was like, ‘well...’ So they did allergy tests on me, and I tested positive for all allergies except for dogs and cats, but in a mild way. So it’s like,

‘okay, that’s interesting, whatever.’ But that was really kind of all they had to say, so it’s like, ‘okay, that’s it?’ And I think my skepticism of Western medicine was rooted in that experience.

Poor doctor-patient communication and prognosis fears

Echoing Jeanette’s account of her doctors’ rudeness when confronted with the potential of a lymphoma diagnosis, Glen also judged the quality of communication with his doctor as poor because the doctor was unable to provide answers of a slightly different kind from those lacking in Steven and Allen’s conversations with their doctor. Knowing that his cancer from 16 years prior had returned after experiencing double vision and confirming his condition with his doctor, Glen

...went to see some neurologists and neurosurgeons, and they wanted to give me radiation treatment to treat it. They sent me to a radiation oncologist, but, that guy was a real, he was a jerk, he was an asshole. And so in talking to him about it, he said, ‘oh, there might be some residual damage.’ And when I asked him to explain that, he said I would need a medical degree to understand. So basically saying that he didn’t have the intelligence to explain his medical understanding in lay terms. So I didn’t want to be treated by him at all and I was angry. So then I just decided to research alternative healing.

Participants using herbal medicine to treat themselves for cancer also indicated a need to overcome fears related to their prognosis, in part fueled by concerns voiced by their medical doctors and family members, in order to fully follow through with their positive thinking about their condition and maintain faith in their ability to successfully treat their condition with herbal medicine. For instance, Steven explained how his decision to research the use of herbal medicine to treat his cancer stemmed in part from his positive “attitude about the whole thing,” insofar as his prognosis was concerned (in response to which his doctor exclaimed, “How did you stay so positive, because we thought you were going to die.”), as well as from how he felt his doctors “didn’t really have any answers for me on what they were going to do or how we

were going to treat this.” And Jeanette recounted how her symptoms of cancer were “really frightening. But we can’t fear these things. We cannot fear them. We have to ask for guidance, and we have to ask for help, and God will provide. . . . It’s not really until you really reach a crisis moment that you have to kind of step across that, there’s like a threshold.”

Further, some participants recounted concerns voiced by their doctors, family members, and friends with regard to their ability to treat their condition with herbal medicine. Tom described having to cross a threshold to overcome fear voiced by his doctors and his family with regard to his prognosis and pursuit of herbal medicine as an alternative to Western medical treatment:

The other thing I had to get rid of was this doctor had put into my thought process that, ‘I’m telling you in five years, you’re going to have bone cancer and we’re not going to be able to do anything.’ I wish he would have never even said that. There was nothing to really base that on other than a theory that he had from what tests he had taken. . . . [And] one physician that I went to in Florida, I remember him sitting there and us talking about the holistic path and him saying to me, he says, ‘You’re never going to be able to stick with this path.’ He said, ‘This is a rigid path that if you don’t do it wholeheartedly, it’s not going to do any good for you.’ And I remember coming out of some of these conversations with these doctors, thinking to myself, why is it you want me to believe that I can’t do this?

Further, Tom’s children also voiced concern with regard to his choice to discontinue Western medical treatment and pursue alternative medical treatments:

Well, with the children I had at the time, their first instinct was, ‘What are you even thinking about not doing this in a conventional way? Why are you, you know, you could die. They [The doctors] are telling you right now if you don’t listen to them, they’re telling you that if you get bone cancer, there’s nothing they’re going to be able to do. That is going to happen.’ And so that was very tough.

Echoing the need for positive thinking expressed by other participants who encountered the cancer diagnosis, Tom described importance of how he thought about his condition upon

maintaining positive thinking about his condition: “If you move in fear, you exist in fear. If you move in thought of love, compassion, and forgiveness, you then vibrate and create that type of energy around you. You attract that, not only in the energy around you, but in the energy of others that are going to help support you.”

While Steven’s wife was “very supportive” of his lifestyle and diet changes in tandem with his “aggressive use of herbs and products,” and even helped him to “rearrange my whole life and prepare meals the way I wanted them prepared, ” others in his life were supportive but “somewhat dubious about my approach because they don’t understand it.” As explained further,

They [People in his life] are very regimented and programmed to listen to their doctor and go into that medical field. And if it doesn’t come from the pharmacy then it’s not good for you, you know. They think this is quackery so to speak. But I couldn’t listen to them, you know. And people would go, ‘Why are you doing this, why are you doing that?’ And I said, ‘It’s going to help me.’ And even after it did, they were still like, ‘I don’t understand.’ You know, there are people who are very hardwired about modern medicine and they just don’t want to hear it; it’s somewhat dubious, you know, it doesn’t fit their framework.

In this sense, participants voiced how they could not “listen” to or internalize fears voiced by doctors, family, and friends in order to maintain positive thinking, both within themselves and among their family, with regard to their prognosis and faith in the ability of herbal medicine to successfully treat their illness. The power of positive thinking to heal from cancer reflects a holistic approach to healing that emphasizes the importance of the connection between mind and body, a connection that participants cited as lacking in Western medical doctors’ construction of their cancer diagnosis and prognosis.

Participants who sought herbal medicine following their initial consultation with a Western medical doctor largely did so because they were unwilling to accept the cancer diagnosis

constructed by Western medicine as a condition with a poor prognosis and few seemingly effective treatments options. The perceived inability of Western medical doctors to provide acceptable answers to participants' questions about their condition and treatment options, in some cases alongside the perception of poor quality doctor-patient communication, influenced these participants to seek alternative therapies for their condition. Dissatisfaction with the quality of Western medical encounters was also cited in tandem with concerns over the risks associated with Western medical treatment for their condition.

Treatment Risks

While some participants' drive to research their condition and natural treatments largely stemmed from their encounters with Western medicine upon falling ill, the desire to pursue herbal medicine additionally stemmed from the perceived risks associated with Western medical treatment for their condition. For instance, Jeanette questioned, "If I had gone on with that diagnosis and it had been lymphoma, do you think I'd be sitting here? Radiation, I mean, you know? It can come on fast, it hit me fast." And, in the course of Tom's research on alternative treatment for prostate cancer, he spoke with other men who had a prostatectomy and found that

...none of them seemed to be completely satisfied with the way it came down. Many of them had things they suffered from because it is quite an intensive network of nerves that they have to go into with lasers. It's better today than it used to be; but, the other thing is, every man I talked to, typically your sex life, the way you experienced it, is completely gone. ... So the more I got into that and talking to people, I realized this was not something I wanted to check into right away.

Some participants who cited dissatisfaction stemming from doctor-patient encounters and the perception of risks associated with Western medical treatment did not pursue Western medical treatment for their condition. Instead, they began using herbal medicine and making other

dietary and lifestyle changes as an alternative to Western medical treatment, relying solely on information gathered from texts, peers, and other CAM and integrative practitioners encountered during the illness experience. Only one participant who encountered the cancer diagnosis, Steven, took an integrative approach and “still had a surgery to remove that cancer.” In this way, participants who developed dissatisfaction with the Western medical encounter and proposed treatment plans took it upon themselves to determine the best way to go about treating their condition. In so doing, participants encountered obstacles in the way of fears voiced by their family and doctors that they had to overcome in order to maintain faith in their ability to use herbal medicine to treat their condition.

Perceived Inefficacy of Western Medicine

In contrast to participants who turned to herbal medicine because they were dissatisfied by the quality of the doctor-patient encounter and the risks associated with Western medicine treatment for their illness, other participants voiced dissatisfaction stemming from the perceived inability of Western medicine to accurately diagnose and/or effectively treat their illness. In these cases, participants weren't so much dissatisfied with the quality of doctor-patient encounter or risks associated with treatment; rather they simply could not find relief from their condition by way of Western medicine. These sentiments were voiced predominately by participants who were afflicted by chronic, contested illness.

Contested illnesses are characterized as illnesses whose origins, existence, and treatment are contested in Western medicine. Many physicians do not acknowledge or recognize contested illness because it is a “medically invisible condition” that is difficult to objectively diagnose and that encompass symptoms that can vary widely among those afflicted (Conrad and Barker 2010).

The diagnosis experience can challenge professional boundaries within Western medicine, such as between different medical specialties, as well as boundaries between doctors' and patients' expertise (Jutel and Nettleton 2011). In the case of contested illness, which is difficult to objectively diagnose and, by extension, treat, doctors may downgrade patients' illness experience to a sort of psychosomatic experience whereby the illness is only subjectively experienced in the patient's mind (Dumit 2006). This led Dumit (2006) to describe contested illnesses as "illnesses you have to fight to get," in that patients often have to fight for legitimation of their illness experience. Examples of contested illness include chronic fatigue syndrome, irritable bowel syndrome, Epstein-Barr virus, multiple chemical sensitivity, fibromyalgia syndrome, and candidiasis sensitivity (Barker 2008; Conrad and Barker 2010; see also Brenton 2009:25).

Candidiasis is a medically diagnosable condition insofar as its manifestations as vaginal yeast infections and thrush. However, the diagnosis of invasive candidiasis, when *Candida* enters the bloodstream, is reserved for patients who are considered high risk (including those who had an intravenous catheter inserted or are immune-deficient) (Centers for Disease Control and Prevention 2015). The condition of candidiasis hypersensitivity is a relatively recent illness construct popularized in the early 1980s with the publication of a book titled, *The Yeast Connection: A Medical Breakthrough* (Crook 1984; see also Truss 1978, 1980, 1981, c.f. Anderson et al. 2001). Characterized by Overland (2011, 2014) as "an illness of vague symptomatology," candidiasis hypersensitivity goes by many names and encompasses a long list of symptoms that are differentially experienced by those believed to have it. Western medical doctors overwhelmingly contest candidiasis hypersensitivity, as is demonstrated by the American Academy of Allergy and Immunology in their 2001 position statement critique of this condition as "speculative and unproven" (Anderson et al. 2001).

“All kinds of symptoms”

Three participants who believed they were suffering from Candida-related illness experienced very different symptoms. For instance, Morgan’s illness started when he became “incurably ill with an ear ache.” After collapsing at work, he ending up “18 hours a day in bed because I was so tired and had no energy,” and experiencing “all kinds of symptoms going on in my body.” On the other hand, Tory “would have these blackout periods where things like pumping gas would activate the candida, and then I would have almost like a space out where I couldn’t think, I didn’t know where I was.” And Carol recounted how “my feet were cracked and bleeding all the time, my scalp was peeling constantly, I had horrible acne, and enormous periods of weight gain... And fatigue, extreme fatigue, like I couldn’t even get up the stairs in the afternoon, couldn’t keep a full-time job, couldn’t get pregnant, my hair would fall out, my tongue was spotted.”

“Nothing was working”

Participants experiencing these diverse symptoms took different approaches to diagnosis and treatment. Mary, suffering from a medically-diagnosed recurrent vaginal yeast infection recounted how “just over the course of a year, I probably went to the physician, I would say three or four times, you know, different products each time, oral, vaginal, and it would just clear up for a little while and then come back.” Carol likewise recounted “going to mainstream medical centers and getting basically treated with antibiotics, and then antivirals... and nothing was working.” Morgan encountered more difficulties as he went to the doctor and “they put me on antibiotics and nothing fazed it. The first round of antibiotics didn’t work, then neither did the second, or the third.” After that, he “ended up seeing virtually every specialist..., tens and tens of

thousands of dollars on tests and doctor visits. And no one could find anything wrong.” And, Tory recounts “getting quite ill, and that’s when they [the doctors] gave me six months to live.” With regard to fibromyalgia, Eileen described sitting “in a couple of waiting rooms actually before I ever heard the word, fibromyalgia. So I never heard it from a traditional doctor.”

Tory and Morgan took it upon themselves to get to the cause of their illness experience:

I found out I had been born with candida. ...mine was so severe that it had migrated through my body in a root system and gotten into my brain. And the doctors did not find that out, I found that out through my investigation. And I found out that if you go to the hospital with a stool sample, they can test the degree of candida that you have. And when they tested me they said it was the worst case they ever tested.

It took me a year and a half to figure it out. I narrowed it down to three things that could have been causing all my issues: ...general chronic fatigue syndrome,... Epstein-Barr virus,... and then this thing called Candida overgrowth or Candida fungal infection. ... I knew none of the doctors that I went to, none of those things were on their radar screen. ... And just one day I was on the internet, just a forum of people who had chronic fatigue syndrome,... and this [integrative] doctor... put a little blurb ... in the forum that he helps people with these kinds of conditions... I made an appointment with him... [and] after about 20-25 minutes he just says out of the blue, ‘I know what’s wrong with you.’ ... So he runs the blood test for Candida ... [and] the blood test for Candida came back positive.

Participants who could not find relief for their Candida-related illness by way of multiple Western medical consultations and the repeated use of antibiotics and antifungals reported feeling “desperate” (Morgan), “really fed up from not feeling well” (Carol), and getting “kind of disgusted” (Mary). Having grown dissatisfied with Western medicine’s inability to, in some cases, accurately diagnosis and, in all cases, provide relief for the ailments of their contested illness, these participants took it upon themselves to research their condition and pursue alternative means of diagnosing and treating their condition.

Finding Relief

All participants who experienced an illness experience and subsequent dissatisfaction with Western medicine stemming from doctor-patient encounters and concerns about the safety and efficacy of Western medical treatments indicated that they found relief from their ailments by way of using herbal medicine. Some participants described a gradual healing process. For instance, while Tom did not consent to Western medical diagnostics to confirm the progression of his cancer, he reported that, “one week became another week and when I started seeing symptoms I had disappear, you know, that was encouraging.” And Glen recounted how “once a year at first I went back to see the neurosurgeon to look at the MRI, and they were pleased at my ability to stop the tumor from growing.” When it comes to contested illness, Mary described how her use of herbs “cleared it [vaginal yeast infection] up,” and Carol described a “slow progression” where she “started reading about diet and nutrition, and I started changing my diet, and I started adding herbs to food.”

On the other hand, some participants described a sudden improvement in their health following weeks of self-treatment. For instance, Jeanette described how she, “...woke up after almost of a month of being very, very ill... I woke up one day and suddenly said, ‘C’mon kids, let’s go shopping. I mean, I went from this to all of a sudden like breakthrough, like curtains opening, you know. I mean, the stars falling and the sun exploded... it was amazing.” And Tory and Morgan described how after several weeks their condition suddenly dramatically improved:

I was taking food herbs and I was doing medicinal herbs, I was doing all kinds of things to build my immune system and working real hard on my diet to try to improve thing. And one day... I kind of emotionally lost it and I said to my husband, ‘You know, I’m going to be like this the rest of my life, and I’m going to be this crazy lady.’ And he said, ‘No, I think this is the end of it...’ And I

didn't believe him. But lo and behold, that was and I didn't have it any more. So whatever was causing the blockage in my brain from Candida dissipated.

I thankfully did that [used herbal medicine] day in and day out for 1, 2, 3, 4 weeks, and I didn't feel even one iota better, not at all, not even that smidgen better. So I started to doubt, are we on the right path? ... So I took it the fifth week, nothing... But the sixth week was a dramatic change in my health and my life that forever changed me. ... I woke up and I instantly felt 80% of normal before I ever got ill. It was so shocking that I thought it was dreaming.

While most participants who turned to herbal medicine following an illness experience did not pursue Western medical diagnostics to confirm that they had successfully treated their illness, all subjectively felt their illness symptoms diminish throughout the course of learning about and using herbal medicine.

Only a few participants who began using herbal medicine to treat an illness had a pre-existing interest in its use cultivated by influences and experiences throughout the life course that, combined with dissatisfaction stemming from Western medicine's approach to their illness, influenced them to further research their condition and begin using herbal medicine. Most participants who started using herbal medicine to treat an illness first learned about its use by researching their condition and alternative therapies and consulting with others encountered during the illness experience. As participants learned about the use of herbal medicine, they developed a concomitant interest in using herbal medicine to treat their condition. Participants' perception of the efficacy of herbal medicine to treat their illness cultivated a renewed interest that further fueled information seeking about the use of herbal medicine that culminated in their regular use of herbal medicine.

Perceived Accessibility and Fit of Herbal Medicine

In contrast to participants who began using herbal medicine following dissatisfaction with Western medicine's approach to their illness, others began using herbal medicine because they believed it was more accessible and/or a better fit than Western medicine. These beliefs were primarily voiced by participants who sustained an injury or did not have health insurance.

Zoe recounted how she was "hiking one day up in the mountains and I jumped off a log and hit a rock and twisted my ankle and my ankle swelled up." Having no previous experience with herbal medicine and with no readily accessible Western medical assistance in this remote geographical location, she accepted some *Arnica* salve from a fellow hiker and applied it to her ankle. As described by Zoe:

I had never heard of *Arnica*. I went home and I went to the health food store and bought this tube of *Arnica* salve, and I went home and kept putting it on my ankle. And I remember that night lying in bed, it felt like someone had just taken a pin and popped my ankle. And the swelling went down and the fluid receded, and in the morning it was as good as new.

Having come "from a pretty traditional background where if you have a headache you take an aspirin, if you get sick you go to the doctor right away," the happenstance circumstance of being in a place where Western medicine was less readily available than herbal medicine and finding herbal medicine effective in treating her condition led Zoe to become interested in herbal medicine and to seek additional information about its use.

On the other hand, Bob described the influence of his recreational use of *Cannabis* during his adolescence. While this period of experimentation was brief, Bob began using more regularly in high school because he was "exposed to it more," he "liked it a little bit more," and he "felt like it was something that [he] could maybe use and enjoy without being irresponsible with it."

These previous experiences using *Cannabis* led him to start using it for medicinal purposes in early adulthood to mentally cope with his physical immobility following a car accident where he sustained life-threatening injuries. As described by Bob, “the amount of time spent without any kind of mobility was terrible, and it was just really rough,” so “at that point I enjoyed smoking *Cannabis* because I was just like, I had nothing else to do. It was more like it helped things not be so monotonous.” While Bob discontinued using this herbal medicine shortly after his recovery, this initial positive experience with the therapeutic effects of *Cannabis* led him to use this herbal medicine again a few years later:

I’ll just say this right from the beginning. I have found the use of *Cannabis* on a daily basis a complete lifesaver and life changer. I mean, I went from kind of being a mediocre student to being a dean’s list student. And I attribute that to being able to focus and not abuse the plant, but allow it to kind of help me, more assisting me. And the fringe benefits are [that] it kills pain, a kind of lightness of mood, and all the other positive effects of it.

Bob’s experiences using *Cannabis* for its medicinal effects led him to develop a fascination with herbal medicine and “a certain respect for the traditional use of shamanistic plants,” which in turn led him to pursue knowledge on the psychopharmacological properties of medicinal plants and begin using herbal medicine on a daily basis.

Lack of health insurance

Some participants described how a lack of insurance, in tandem with a pre-existing interest in herbal medicine or the close proximity of an herbal medicine retailer, led them to begin using herbal medicine. Armed with a pre-existing interest in gardening and other CAM therapies, Lilly described how she began using herbal medicine as a preventative and alternative to Western medicine when she did not have health insurance:

And thoughts kept coming to me, you know, what if this happens or that happens, what would we do? ... I needed to know how to take care of my family, you know. Who's going to take care of my family but me? And it was really instilled in me to search and find answers to wellness, what if? I definitely don't live in that fear mode, but when your children are little, I think moms sit around and think what if, what if? ... So I would go to the library and find a book and it was definitely speaking to my soul purpose because I couldn't get enough... So everything kept opening, doors opened left and right everywhere that I went. Somebody was teaching a study on herbs or a little town ... I was driving by and I saw a little herb class.

In contrast to Lilly's desire to be able to care for her family in the face of not having health insurance, Alisha's interest in CAM led to its use after she lost her job and health insurance. As explained by Alisha, this situation "kind of forced me to do a lot with energy healing..." As she started getting older, she began "looking for ways to keep myself healthy," whereby her path into using herbal medicine was "kind of a natural evolution of being involved with alternative healing practices, and then that [herbalism] was just kind of an extension of kind of integrating other things into that."

Theresa, a college student who "was even so poor I couldn't really afford the mainstream student insurance at the time," started experiencing "very bad fatigue" and "became very mood-wise antisocial." Thinking that she might be experiencing chronic fatigue syndrome and "just feeling so no energy, nothing," Theresa stopped by a health food store within a short walking distance from her school and discussed her health ailments with an employee who recommended a few products. Having no previous interest in the use of herbal medicine, Theresa "...just bought whatever he told me to get and I went home and started taking those things and it became the difference between night and day, like, 'oh, this is what it is to feel alive (laughs) and not be a walking dead person and to actually have the energy, wow.'" Following this experience, Theresa

maintained that “even if I could [have afforded student health insurance] I would not have chosen it. Once I had the door open to natural health, I just went down for that.”

Some participants who believed that herbal medicine was more accessible and a better fit to treat their ailments than Western medicine had a pre-existing interest in gardening and CAM that led to their interest in herbal medicine, an interest that was strengthened throughout their use of it. Other participants developed an interest in herbal medicine solely as a result of finding it effective in treating their ailments. These participants’ emergent interest in herbal medicine in turn cultivated an interest in learning more about its use that led these participants to begin regularly using herbal medicine. In these cases, experiencing a situation where herbal medicine was deemed more accessible and/or a better fit than Western medicine was the primary reason that these participants first used herbal medicine.

Pregnancy and Health

While many mothers in this research indicated their continued use of herbal medicine during pregnancy and with their children as they grew up, six participants discussed how they began “really” using herbal medicine during pregnancy and child rearing. These participants identified varying degrees of interest in, knowledge of, and experience with herbal medicine prior to becoming pregnant, including their parents’ and/or grandparents’ use of herbal medicine growing up and/or their early experiences with nature cultivated an interest in the natural world and medicinal plants. As adults, these participants indicated additional influences upon their choice to use herbal medicine, including the influence of others, such as their child’s father and midwives, herbal texts, an interest in CAM, social movements, and work at health food stores that sold herbal products and at farms where medicinal plants were grown and processed.

Their interest in herbalism cultivated through experiences and influences throughout their life course coalesced with the commonly held desire to nourish and grow a healthy baby, where many of these participants characterized a healthy baby as one who was not exposed to pharmaceuticals, chemicals, and, in some cases, vaccinations. All participants who began using herbal medicine while pregnant or nursing received pre-natal health care from a medical professional and/or a midwife. Reflecting widespread medical cautions against the use of pharmaceutical medicine while pregnant (CDC 2015), participants indicated strong concerns about the risks of using pharmaceuticals while pregnant and nursing. Those who relied primarily on Western medical care used herbal medicine largely to provide additional nourishment and to ease discomfort while pregnant and nursing, while participants who indicated a primary reliance upon a midwife's care additionally relied on herbal medicine to prevent and treat emergent health issues and sought Western medical care only when deemed necessary for the health and safety of their self and their child.

In this section I discuss how participants began regularly using herbal medicine once they became pregnant and while child rearing. This entails a discussion of how they learned to use herbal medicine, how they chose between herbal medicine and Western medical care when illness arose, and of their desire to avoid pharmaceutical use throughout pregnancy and child rearing, both for themselves and their children.

Learning the Wise Woman tradition

Participants who began using herbal medicine during pregnancy often referred to their knowing that women have used herbal medicine for centuries to assure the health of their family, a knowledge that was cultivated from experiencing and learning about their families' use of herbal

medicine growing up, experiences with nature as a child that cultivated a connection with plants, reading herbal texts in the Wise Women herbal tradition, and learning about the use of herbal medicine from their midwives. Both Amanda and Tara believed that herbal medicine was more natural and gentle to use while pregnant and nursing and made a conscious choice to use herbal medicine before resorting to pharmaceuticals because of an “instinct” that has “always been with us in a way” (Amanda). Or, put differently, “I know instinctually that I can learn from what other mothers and grandmothers and women historically have been doing as part of who we are” (Tara).

Avoiding chemicals

Participants who identified a belief in instinctual knowledge and intuition indicated their reliance upon this form of knowing when deciding what they consumed and were exposed to during pregnancy, as well as when observing their children’s health and determining appropriate treatments for emergent ailments. After Tara had her first child, she felt “this instinctual need to go out and gather,” in part “as an introduction to being a mother” where she

...would just walk with Caleb [her son] on my back in a basket and collect plants that spoke to me. And I was just collecting, there wasn’t any reason. It wasn’t like, ‘oh, I need to find some mullein because I’m having some breathing issues, or I have an infection. It was just because they were beautiful. There was a connection to the plants. But it [herbal medicine] is something that is intuitive...
(Tara)

Tara referred to an instinctual knowledge of using herbal medicine that everyone has, but that not everyone recognizes because “there’s been a lot of layers put in front of those instincts, for men and women,” where the layers refer to “messages that we are choosing to receive from outside sources, or from other groups of folks that are doing research in a pharmaceutical way or

isolating compounds in a certain way. And we're receiving that more readily all the time as opposed to providing ourselves with a little bit of space to listen to our instincts."

In this way, Tara cultivated a deeper connection with plants and become more conscious of what she consumed because "everything that I put into my body is going to be affecting someone else. And I'm making that choice for that individual, and that was meaningful to me." Amanda also referred to how her "mother's instinct" led to an aversion of pharmaceuticals and other chemicals while pregnant and nursing. "When I was pregnant, I think just like our mother instinct or whatever, I knew that I did not want to put a bunch of crap in my body because, you know, with breastfeeding it would all go into my baby's body."

To use, or not to use, herbal medicine

Participants who indicated their learning by "instinct" and "intuition" and described their experiences with Western medicine during pregnancy and child rearing often referred to a faith in themselves to monitor and assist in their baby's health, rather than solely placing their trust in a medical doctor. For Tara, the experience of taking her newborn to a well-baby exam with a pediatrician and finding that the doctor was unable to verify anything about her child's health status that she didn't already know further concretized her turn to herbal medicine:

When Caleb was little and taking him to his well-baby, and I remember thinking, well, my baby is nursing, he is fine, and I'm paying \$120 for this visit out of pocket for 10 minutes. And I remember observing the pediatrician and thinking, well, I saw that too, you know, they're telling me and feeling the child and I'm thinking, well, I don't really need to be here, you know, and this is a lot of money to be here for them to tell me that my child is healthy. ... My partner, he used to work with herbs, just an interest, a hobby of his own. So we would talk about different plants or different books, and then, you know, I realized that if my child is healthy, I don't have to take them to pay somebody else to tell me that they're healthy; and, that if my child is sick, that there's some reasonable things I could

do to introduce myself into using herbs to heal or remedies in the kitchen. So I did that.

Tara's experience illustrates the emergent desire to have more control over, participation in, and individual responsibility for the health care of her child, a desire also voiced by Lilly who felt responsible for her family's health in the face of not having health insurance. Tara viewed going to the doctor as a conscious choice rather than as an annual obligation, a sentiment voiced by many mothers. These experiences do not reflect so much a dismissal of Western medicine doctors' authority; rather they established a boundary between them and their doctor's authority to evaluate their child's health. While "working with plants is the first thought, that's what we do," Tara would still "consult an allopathic physician and talk to them about their experience" if needed. And, if her "children would feel more comfortable going to talk to a doctor, or a physician or nurse practitioner and listening to them and taking an antibiotic, I support them on that."

The dilemma of whether to use herbal medicine or Western medicine for some participants' infant child's health was sometimes a difficult choice to make because of the risks associated with not using Western medicine for conditions that might necessitate its use and the liability that parents assumed for the self-care of their child's health care. While Zoe was already using herbal medicine at the time of her pregnancy, she described how she sought Western medical assistance while child rearing but did not agree with her doctor's evaluation, which in turn led her to "trust her gut more."

There is something about having a child that, I was willing to experiment with me, but when you have a child, especially before they're verbal, you're scared, you know. Like, what if I do something wrong and I'm responsible for killing my baby, you know. It's unthinkable. So I would go to a doctor and get his take on it and I just never agreed with what he said, like it never resonated with me. And so I realized I needed to trust my gut more with that.

And Amanda, whose pregnancy with her second child “reawakened that passion” for herbal medicine, also found herself in a dilemma with regard to treatment choices when her infant became ill:

You know, with Anthony getting sick so early in his life with the staph infection, I really had to trust the doctors on that. So that was a very humbling experience because I’ve never had to take my daughter to the hospital, never, you know. The doctor was like, ‘oh yeah, let’s do antibiotics because he has this infection,’ and I’m like, ‘I’m going to try garlic instead.’ But when it came to that with my three week old child, and I remember talking to my partner and I was like, ‘can’t we just figure something else out?’ And it’s like, ‘no, we better trust the doctors on this one.’

Participants’ decision of whether or not to seek Western medicinal attention was particularly a difficult choice to make when their infant child was sick. As infants are vulnerable to illness and disease and have not yet developed the ability to effectively communicate what ails them, some mothers indicated their reliance on “intuition” and “gut feeling” to help them determine the best course of medical attention for their infant’s health, a way of knowing espoused within the Wise Women herbal tradition in America (Weed 2001). This characterization of the motivation to use herbal medicine during pregnancy reflects the idea of a maternal instinct, a “biological-based in-born knowledge” that informs how women should care for their children (Kennedy-Moore 2014). Participants additionally indicated relying on their observations of their child, empathically identifying with their child, and seeking information from midwives, medical practitioners, family, peers, and texts in order to decide whether or not to seek Western medical care or to treat their child with herbal medicine. The deliberation over which medical approach was the best approach to their infant’s health seemingly stemmed from their simultaneous desire to maintain their child’s health by avoiding pharmaceuticals and chemicals and to ensure their child’s health by resorting to pharmaceutical medicine if they believed it was necessary to treat their child’s health condition.

“Really” starting to use herbal medicine

While Tara and Amanda first began using herbal medicine while pregnant and child rearing, other participants had already dabbled in herbal medicine prior to becoming pregnant. These participants described how the pregnancy experience prompted them to “really” start using herbal medicine. Maggie, whose interest in herbal medicine was cultivated through various work experiences on farms and in health food stores, “really started to research and use some [herbal] products” after becoming pregnant. While Jessica and Molly were already using herbal medicine following the influence of the 1960-70s hippie movement, both began using herbal medicine more during pregnancy: Jessica “really started consuming the Celestial Seasonings teas, just left and right, just nonstop, because I wanted that additional health benefit.” And Molly recounts how “when I got pregnant out there [in Los Angeles] with my son, I pretty much read every book in the Hollywood Library on herbs and vitamins and natural pregnancy.” As explained further by Molly, “Oh boy, I wanted to build the healthiest baby I can build, and that’s why I read every book I could get in the Library and did what it said to do.”

Andrea likewise recounted how pregnancy influenced her use of herbal medicine. When asked about influences on her choice to use herbal medicine, Andrea explained,

I think I would almost have to say, really, that I think it was, more than anything else, getting pregnant... and I started looking into vaccines, which really escalated my research. And then, of course, having to defend my choices because I was, I wouldn’t say ostracized, but nobody understood. They thought it was horrible that I wasn’t going to vaccinate my child, and abusive some of them. ... I would say, that’s what really catapulted me into getting braver, really, you know, taking more of that leap of faith.

Andrea’s path into using herbal medicine was seemingly concretized as she researched natural alternatives to vaccinations in an effort to defend her choice to not vaccinate her child, where in

the course of her research she learned more about how to use herbal medicine and became more confident in its use. In these cases, a pre-existing interest in herbal medicine prompted these participants to learn more about its use during pregnancy, which in turn led them to begin regularly using herbal medicine throughout and beyond the pregnancy experience. Thus, while all participants who began using herbal medicine while pregnant indicated a diversity of influences and experiences that led to their interest in herbal medicine, alongside varying degrees of knowledge about and experience with its use that led some of these participants to dabble in its use, it was not until becoming pregnant that these participants began using herbal medicine on a regular basis. Participants who used herbal medicine while pregnant or child rearing identified additional concerns about the safety and efficacy and overuse of pharmaceuticals echoed by many other participants described below. However, mothers were especially concerned about the growing use of pharmaceutical medicine among children in the US.

Children's dependence on pharmaceuticals

Many mothers voiced concerns with regard to the growing use of pharmaceuticals among children, often following observations of children in institutional settings. For instance, Andrea describes the use of pharmaceuticals by her daughters' peers at school as tragic:

When Shelly [her daughter] started to go to school ... I just thought it was so tragic, these kids are on all these anti-anxiety drugs and anti-depressants, and of course tons of allergy medications... that is so wrong, it's so wrong. ...I mean, that's just, I just think that's tragic, really tragic. I mean, over and above the side effects, the dependency, that mentally these kids feel that they can't function without medication.

And Amanda describes how her experience working at a children's group home influenced her belief that it is sometimes criminal for teenagers to be on so many pharmaceuticals:

I remember when I was working [at the group home] and I worked with teenagers. And God, they're on so much stuff. Sometimes I feel like it should be illegal to put teenagers on so much medicine. But remember them [the teenagers] saying, like, 'oh, I take such and such to deal with the side effects of this, and then I do this because this affects you in this way.'

Thus, in some cases, participants' belief that pharmaceuticals are risky to use during pregnancy and child rearing extended to inform their perception of the risks associated with the "overuse" of pharmaceuticals among children. As discussed below, some other participants voiced concerns about the overuse among the public in general following vicarious experiences with Western medicine whereby they witnessed others' dependence upon pharmaceuticals.

Pharmaceutical Concerns

While some participants cited the salient influence of a desire to avoid risks posed by their use of pharmaceutical and chemicals while pregnant upon their choice to use of herbal medicine, variations of the desire to avoid pharmaceuticals was voiced by all but one participant in this research. And, all participants indicated a strong preference for using herbal medicine over pharmaceutical medicine. It was often unclear, both to me and participants, whether concerns about pharmaceutical medicine precipitated participants' initial use of herbal medicine, or if beliefs about pharmaceutical medicine emerged throughout the course of participants' use of herbal medicine and thus fueled their continued use of herbal medicine. Nonetheless, participants overwhelmingly indicated the importance of their beliefs and attitudes with regard pharmaceutical medicine on their choice to use herbal medicine throughout interviews. Two broad themes emerged in participants' concerns about pharmaceutical medicine: concerns over the safety and efficacy of pharmaceutical medicine and concerns about the overuse of pharmaceuticals, both of which are, in part, rooted in distrust of the medical and pharmaceutical industries.

Safety and efficacy

Three-quarters of participants voiced concerns about the safety and efficacy of pharmaceutical medicine. The most often cited concern was with regard to side effects associated with pharmaceutical medicine. These participants often described how pharmaceutical side effects stemmed from their synthetic (i.e., unnatural) quality, which led them to view pharmaceutical medicine as less safe than herbal medicine. Participants also discussed side effects from pharmaceutical medicine with reference to the profit motive underlying this industry. In some cases, these concerns were inter-related. For instance, Carol described her distrust in pharmaceutical medicine as grounded in a distrust of the profit motive, itself manifest in the perception of poor pharmaceutical quality control and numerous cases of widespread adverse effects arising from pharmaceutical medicine use whereby she believed that the companies were not held appropriately accountable because they incurred far more profit than costs.

I don't believe any claims about any prescription drug that comes out. I don't believe that they're healthy for me at all, so I would not put them in my body because I would be afraid of dying... I mean, they just get slapped on the wrist for killing thousands of people knowing that something has a horrible side effect. They don't pull it, 'oh, we didn't pull it, we didn't know that, we get a \$5 million fine,' but you made billions. You've already made the billions, so you pay a \$5 million fine, no biggie... Why would I go and take something completely risky that somebody made in some factory and I don't even know what's been dropped in the hoppers? ... I've never had a problem or side effect from any herbal tincture that I've taken. But I have had problems with Diflucan, I have had problems with antibiotics, I've had problems that really lasted me a long time and made me seriously ill.

Likewise, Theresa also connected the risks associated with pharmaceuticals with their synthetic quality and the profit-driven pharmaceutical industry, whereby she described how pharmaceutical medicine is purposely made synthetic so that it can be patented and thus ensure profitability; and how the advertising of pharmaceutical medicine, rather than increasing her

interest in pursuing that treatment, increased her perception of the risks associated with pharmaceutical medicine:

Most of the drugs, when they take what's in nature and they alter it, and primarily they alter it so they can patent it and say, 'this is our product, you have to get it from us.' And then there's all this money connected with it. Then you have all these side effects. I'm just amazed that people will still, after a television commercial, they will have this older couple and they're by the beach and they seem so mobile and it's talking about whatever the latest joint drug is and at the end of the commercial it's taking 30 second or more to quickly list off about 25, 30, 40 different things that could happen while you're taking this thing. And all the major complications you can have with this. So that doesn't communicate healing to me; that communicates lots of risk.

Other participants echoed Theresa and Carol's sentiments about how the side effects associated with pharmaceuticals seem to negate healing and even worsen one's health. As mentioned by Bob, "It's like now we're realizing, like, look at all the side effects. Then why would we want to make ourselves worse by trying to heal ourselves?" And Tory describes how "one of the things that I've noticed with medications is that the side effects end up being as great as whatever that person is trying to do." Thus, some participants not only believed that pharmaceutical medicine was risky, some believed it worsened one's health.

Some participants described how herbal medicine was less risky than pharmaceutical medicine. For instance, Zoe described how the lack of side effects experienced when using herbal medicine influenced her perception of herbal medicine as safer and gentler than pharmaceuticals, but not without acknowledging that herbal medicine can also have side effects if improperly used:

The side effects of pharmaceuticals are staggering to me. And I just don't think that to heal your body you have to make it quite so sick, you know. I think you really have to just work with where your body is and help it get stronger and get over whatever it's suffering from. So, to me, the lack of side effects is really important to me, which is not to say that plants can't be toxic because of course

they can. But, you know, when you use them correctly and wisely, they're so safe and gentle.

Echoing Zoe's assertion that herbal medicine can have side effects just as pharmaceuticals can, other participants cautioned that despite the widespread perception that herbal medicine is safe and gentle, it should be used with as much care as when using pharmaceuticals. Many participants' belief in holism provided a foundation for their belief that herbal medicine was safer and gentler, whereby herbal medicine was thought to have fewer side effects because it consists of whole plants with active compounds that work together to mitigate adverse effects. In contrast, many participants believed that pharmaceutical medicine (and some herbal products) consists of active components that are isolated from one another, which leaves an imbalanced product that lacks the compounds that complement each other in their effects. At the same time, some participants also expressed similar concerns about herbal medicine that is compounded into capsules and tablets whereby instead of utilizing the whole plant, some encapsulated herbal medicine contains specific isolated compounds at the neglect of other compounds that help to mitigate adverse effects. For instance, in response my question of why Zoe didn't take herbal medicine in capsules, she explained how:

Pharmaceutical companies kind of decide, like the potent part of St. John's wort is blah blah blah, so we're going to up the amount of that in these capsules. So you don't get a balanced, it's not plant matter, it's chemically created. And to me, the plants are all about the synergy between its parts. I can't say this is the once element that makes the plant work. I think they work in conjunction. It's like the yoke of the egg and the white of the egg, you know, you can't cut out the yolk because the white helps you digest the yolk and the yolk helps you digest the white.

Participants' descriptions of the side effects of herbal medicine also stemmed from a holistic understanding that herbal medicine also has different effects depending on how the herbal medicine interacts with particular bodies and other substances the person ingests, how people use

herbal medicine, and people's expectations with regard to the effects of herbal medicine. For instance, Mary described how both pharmaceuticals and herbal medicine can have different, even adverse, effects depending on the person's constitution at the time:

It [herbalism] isn't an exact science, but it's also because we are human beings and every body is different, everybody processes things differently. Even with pharmaceuticals, even though you take a product and it says it's going to settle your stomach. Well we pretty much all know that Tums, if you've had indigestion, it's going to help a little bit, some people it helps really a lot and for others they have to go through the whole bottle, and others take one. So again, even if it's a pharmaceutical thing, it's not going to work the same with every body, and as we age things are different. ... That's why I tell people too with the herbs, start with the smallest dose. You can always increase it if you're not, it's like after 2-5 days, if you're not noticing some change, increase it a little bit. But don't just start with the maximum and work back, it's like, that's when you're going to have the bad reactions.

And Tom described how people should respect herbal medicine as much as pharmaceutical medicine because the effects of herbal medicine may naturally vary, both in relation to other medications consumed and depending on what exactly was consumed.

I think a lot of times herbs don't get the proper value for what they've achieved because they weren't used right. Another important thing you have to realize with an herb is that it's not chemical, it's coming into the system and doing what it does naturally. ... We've changed that in our society of allowing the body to do what it wants to do naturally, we keep it confused a lot of times with other things we are putting into it that are not natural, they have a chemical substructure. So those are some things I think that as you move into herbs you need to share with people. You know, having the respect for it like we try as a society to put out there with pharmaceuticals. You know, be aware of what you're taking, what you're taking is also really important, maybe not to the same type of importance you're putting on the pharmaceuticals because the herbs are more natural and in most cases are not going to harm you, but anything in excess is not good.

Further, Allen cautioned against substituting an herbal medicine for a pharmaceutical medicine, particularly when holding expectations about the efficacy of herbal medicine that misinform their medicinal use of that plant.

People think, ‘oh well, herbal medicine is automatically benign,’ and maybe, but you have to be careful with that because they want to replace a pharmaceutical with an herb. So I would say to look at them as an opportunity, but also with a skeptical eye, that they’re not going to be as strong as a pharmaceutical necessarily, or they could be more strong than you imagine and create a stronger effect than you would imagine.

Thus, while participants generally believed that herbs are more natural and generally safer to use than pharmaceuticals, particularly when consumed in their whole plant state, many participants also expressed caveats and concerns about the risks associated with herbal medicine use that revolved around the need for understanding how to properly use herbal medicine, such as by knowing what is in the herbal medicine one is taking, properly using the medicinal plant for its intended purpose, having proper expectations for its efficacy depending on the individual body’s particular constitution, and through experiential learning by way of observing the effects of herbal medicine upon individuals’ unique bodies and revising the practice of herbalism accordingly.

Profiteering in the pharmaceutical industry

In addition to concerns about the safety and efficacy of pharmaceutical medicine that were often related to concerns about the profit-driven component of the pharmaceutical industry described above, many participants expressed additional concerns about overuse of pharmaceuticals among the American public that also often reflected a distrust of the profit motive underlying the pharmaceutical industry. Some of the participants who began using herbal medicine out of a general interest, rather than in response to experiencing a situation that prompted its use (as discussed in chapter 3), indicated that observing others’ dependence on pharmaceutical medicine influenced their perception that the medical, pharmaceutical, and agricultural industries were unsustainable. This negative evaluation of the pharmaceutical industry prompted their desire to

begin using herbal medicine in an effort to live in a more sustainable manner. Participants also voiced concerns about the medicalization of health issues, particularly when a pharmaceutical is advertised to treat this issue. Additional concerns surfaced with regard to the industry's claims about the efficacy of pharmaceuticals, with some participants indicating a belief that the industry purposefully keeps people from being well so that they can continue to profit from their dependence on pharmaceutical medicine. As with most concerns about pharmaceuticals, these themes overlapped in participants' discussions about pharmaceutical medicine during interviews.

Vicarious experiences with Western medicine, such as by seeing family members and clients at work dependent upon pharmaceuticals, sometimes alongside the influence of social movements led some participants to believe that the agriculture, medical, and pharmaceutical industries were unsustainable, whereby these participants began using herbal medicine as a more sustainable alternative to pharmaceutical medicine. For instance, while always curious about CAM, Betty describes how "something just woke up in me, I just started having an awareness that a time is going to come when we'll have to go back to our herbal tradition and have to go back to a different way of living." This reawakening was attributed to seeing her mother and clients in the workplace "dependent on pharmacology."

It sickened me, it just really sickened me, the side effects of these drugs and they weren't really getting better. It was just like putting a Band-Aid on something. Actually, it was like pouring salt on wounds, not even putting a Band-Aid on wounds. And I just started realizing that there's a lot more going on in this country, it's just more, it's hard to put it in perspective without sounding like a conspiracy theorist because that's not where I'm going. But there's just this pattern that we have fallen into, and we've gotten so far away from who we are, and that's when this thing started waking up in me. And it was like, I want to know something else besides this, like I want to find out something else other than what I'm seeing. And that's kind of how I stepped into herbalism.

Jody also recounted the influence of seeing her parents and clients from work and “just all the pills and pills and pills and pills and pills.” After learning more about plants and herbal medicine, Jody

...started getting really mad and pissed off at the food industry and the pharmaceutical industry and how they trick people, Monsanto and our dependence on oil and agribusiness. And, you know, it just all turned into this big ball where I just want to be sustainable... I have some anger in me I guess because I feel like all the big businesses and capitalism and stuff are tricking people and they're poisoning our food and they're poisoning our water and our environment, and the pharmaceutical industry... sometimes I just feel like global corporations just lead lambs to the slaughter.

Likewise, Angie also voiced a distrust of industry that was in part cultivated during her participation in the Occupy movement, whereby she “thinks that we are heading in the wrong direction, just destroying every environment that's out there, and just wasting. So anything that I can do to keep everything local and not give to big businesses and corporations really intrigues me.” In this way, some participants with a pre-existing interest in herbal medicine also voiced a distrust of the food and pharmaceutical industries that stemmed from vicarious experiences with Western medicine and/or pre-existing political beliefs. These beliefs and attitudes fueled these participants' choice to use herbal medicine as a means to lead a more sustainable life.

When it comes to the power of pharmaceutical companies to persuade people to take pharmaceutical medicine, participants overwhelmingly referred to how the medicalization of high blood pressure justifies the marketing of statin drugs, which were seen to make people dependent upon a pharmaceutical in order to maintain the Western medical construct of ideal blood pressure. Participants indicated an avoidance of maintenance drugs for conditions that they were not convinced necessitated the use of a pharmaceutical drug. For instance, Steven and Molly

described how they resist the medicalization of high blood pressure and dependence upon statin drugs:

I'm not a big cholesterol freak, I don't trip off of high cholesterol unless it's astronomically off the charts or something because I think they created their own monster with that. You know, I think it's really overstated. I read a study about a year ago I guess, that said that women with high cholesterol live longer than women with low cholesterol. So maybe it's not the demon we think it is, maybe it's something that has been propagated by the medical field to sell us things, you know. But I think the drugs are more detrimental than their benefits.

I think your good cholesterol is supposed to be at least 45, and if it's 40-45 they consider that pretty good. And mine is 96, so it's really good, but the total cholesterol is probably 250 or 270 or something and I think they want it to be under 200. But I don't really care about regular medicine. They can think whatever they want, and if I die from my cholesterol being too high, there you go. You know, I'm going to die at some point, you know, we all are. I'd rather live life on my own terms and not go to doctors than take statin drugs and do this and do that.

Theresa invoked additional evidence for the medicalization of high blood pressure in her concern of how blood pressure drugs might be prescribed even when a person doesn't have high blood pressure, so as to potentially prevent having high blood pressure:

You know, this is the new thing that's surprising to me in the mainstream medical society is that while you don't actually have blood pressure problems now, 'Ms. or Sir., but we want to give this to you as a maintenance drug to keep you from that.' I'm like, 'wow, so even when you don't have the condition they're going to give you the drug for it.'

Thus, in addition to concerns about becoming dependent on pharmaceuticals to maintain or treat a medicalized condition, some participants were also concerned about the practice of prescribing pharmaceutical medicine in order to prevent a medicalized condition.

Many participants described additional concerns about the medical and pharmaceutical industries' pursuit of profit at the neglect of effectively healing illness. For instance, several participants believed that pharmaceuticals were less effective than herbal, diet, and lifestyle

changes in treating psychiatric disorders, cancer, and viruses. In these cases, participants believed that the medical and pharmaceutical industries offer pharmaceutical medicine to maintain illness by treating the symptoms instead of offering other, seemingly more effective, treatments that might address the illness at its roots. This perception of the pharmaceutical industry as maintaining, rather than curing, illness led some participants to distrust claims about pharmaceutical medicine's efficacy in treating particular ailments. As described by Bob, Morgan, and Molly,

I guess I don't have a lot of faith in or a lot of respect for the medical community and the pharmaceutical industry. You know, you see all these commercials about all these different pills and designer drugs. And I don't know, to me, it makes me think of the American way, and it's not to say it's just in our country. For me, it's a way to be callous and not go the heart of the issues, you know, with psychiatric medicine.

So then you get into the politics of cancer, and if you don't understand how the [medical] system works, the system is not about curing cancer, it's about making money off of cancer, and all the treatments and all the protocols. And truth be known, but they'll never tell that truth over public airways.

You know, very many herbs will just kill viruses flat out, you know. And if people just knew that. But there's not enough money for the drug companies. I believe it's very politically and financially motivated. Just, I think it is. It's just obscene, just obscene and sad.

These participants often referred to how pharmaceutical companies “get away” with profiting from illness because people don't know that there are other, more effective, treatments available. In addition, some participants pointed to the power of advertising to gain the public's trust in the medical and pharmaceutical industries. As described by Carol, “A lot of the advertising you see on TV regarding doctors, it's trust your doctor. They're always communicating this message that your doctor is the one that you should trust, and so they never think to question that whatever their doctor is doing may not actually be in their best interest.” And, Morgan and Glen speak to the “power of programming” and “brainwashing” through social institutions, including

the media, schools, and religion, which instill the idea that the public should trust the authority of the medical industry and medical doctors. For example, Morgan described how advertising and the widespread availability of pharmaceutical medicine illustrates the power of institutionalized health care to promote the public's affinity for Western medicine and preclude widespread acceptance of herbal and other CAM therapies.

I know how strong the power of programming, the power of advertising is. We are programmed from our youth to believe that the current system has all the answers. We are programmed by seeing drug commercials every 30 seconds. If you watch TV, there's some drug commercial on at least 4-5 times every half-hour, if not more. We see drugstores that outcompete gas stations on every corner, you know, you see a gas station on the corner, you probably see a drugstore on the other corner. And we are tethered to the current system because we spend hundreds of dollars a month on what we call health insurance, and that keeps us permanently tethered to that system. And of course when people are sick and they're paying all these health insurance premiums, 'I've got to use it.' It's a false obligation to use that system and to trust that system because you're invested in that system.

When asked how the use of herbal medicine impacted the rest of his life, Glen described how he came to resist the authority of Western medicine as propagated through institutional agents of socialization, including school, media, and religion.

I became much more questioning of standard beliefs that we are brainwashed into believing in our society. You know, we really, really our whole culture is based on this. We are really brainwashed from an early age to respect medicine and the professions, you know, like 100 priest-like entities. ... And all the time, all the ways that your beliefs have been developed through grade school, high school, college, the news media, you know, going to Church on Sunday, all of that. You know, it's all part of respecting, learning to obey. That's one of the big things we learned as children, to obey, which in some ways of course is beneficial, but it is also destructive.

In this way, these participants believed that the pharmaceutical industry dominated the medical industry and infiltrated other social institutions with the sole goal of profiting from the public's trust in Western medicine. Other participants similarly referred to how their choice to use herbal

medicine entailed a change in faith from the ability of doctors and pharmaceuticals to faith in their self and plants to heal emergent ailments and maintain their health. Or, put differently, participants indicated learning to trust herbal medicine more, and Western medicine less, throughout the course of using herbal medicine. As described by Lilly and Andrea,

The first step in using herbs and going off the beaten path is the hardest step for a lot of people to take, it's one of the hardest steps in their life because, everything, it's kind of like changing your religion, you know, because it is a big deal... for you to take that first step, to say, I'm not going to listen to the doctor, which they [a lot of people] think is deity, to stop and listen to my heart. I mean, that step alone has changed my life and everyone around me, everyone that knows me knows it's changed my life... if anyone is searching, they don't even have to worry. If they have the thought, their first free thought, doors will open left and right... your first free thought and then all of your angels show up to help you, to keep thinking, you know.

It's almost like, I attend it to religion because you really, it's like what you believe in, what you believe is going to help you—that's what really makes a difference. Like my father, trying to get him to take any kind of a vitamin or anything, no, no, no. But, my gosh, he's got ten medications which, gosh, he's got the triple bypass so he's got this heart and they put him on a diuretic, and I mean, a diuretic, c'mon. It's really contra-indicated here. 'But my doctors said...', Well, he needs to do a little more study and not just believe the drug rep, but, of course, who am I? So, anyway, that's his religion, that's what he believes in.

In sum, nearly all participants indicated concerns about the use of pharmaceutical medicine and distrust in the pharmaceutical industry. These beliefs and attitudes reflected distrust in the ability of pharmaceuticals to safely and effectively heal health conditions, as well as distrust in the profit motive underlying the medical and pharmaceutical industries. While the influence of beliefs and attitudes about pharmaceutical medicine were indicated as especially salient by participants who sought herbal medicine during pregnancy and in some participants' efforts to live more sustainably, it was often unclear whether these beliefs and attitudes precipitated other participants' choice to begin using medicine. In any case, these attitudes and beliefs about the

pharmaceutical industry functioned to strengthen participants' commitment to using herbal medicine.

Navigating the Boundaries of Western Medicine

The vast majority of participants indicated that their use of herbal medicine and other natural therapies was their “first thought” and “first choice” when it came to treating illness. However, there are many important caveats and exceptions. Several participants indicated that they go to integrative, holistic, homeopathic, functional food, and naturopathic practitioners, while many women indicated that they also periodically see a Gynecologist for exams and pathology (e.g., pap smears). Some participants indicated regularly seeing a medical doctor because they utilized an integrative approach to their health, for regular check-ups for diagnostics in order to prevent emergent illnesses, to maintain a partnership with a Western medical doctor in case there was a need for them to use Western medicine, and/or because their insurance or government program required that they do so.

For instance, Steven leaned heavily towards an integrative approach, indicating that he “want[s] to hear what they [Western medical doctors] have to say, ... I try to incorporate what I know with what they're telling me and make a more full rounded approach to my problems.” And Jessica explained how, “I have faith in my doctor, he's a wonderful man. But I have equal faith in the iridologist.” In contrast to actively taking an integrative approach to health, some participants sought the use of Western medicine for diagnosing and preventing health conditions, such as by using X-rays and other imagery techniques, and pathological testing of blood and other specimens as an advanced technological means of gaining insight into their body's health status that herbal medicine and many other CAM therapies do not utilize. For instance, both

Steven and Alisha indicated going to the doctor to ensure their good health: “Sometimes I go [to the doctor] just to make sure I don’t have something, to get an x-ray or something to see into myself... I don’t try to say, ‘no, I’m never going to the doctor,’ because they have things that they can check you with that you can’t do better and intuitively. And it’s not a game; you better have it right,” “I normally don’t go to doctors... I basically am going to a doctor just to see where my levels are, my vitamins, minerals, hormones, things of that sort.”

And, for Alaina and Morgan, going to the doctor is a means of maintaining a relationship with a Western medicine provider:

I do see a medical Dr. I definitely make a choice about when I need to do that. And, I feel like it’s not at the drop of a hat, so to speak. I mean, I’m blessed with the opportunity to make use of, my husband’s job provides health insurance so we can have a partnership with a medical doctor. Then as far as courses of treatment that they might recommend, you know, I definitely question it or think about what’s necessary.

I can’t tell you the last time I’ve been in the emergency room or anything like that. I just go to my doctor once or twice a year and get a health care checkup, do a blood drawn and all that. And just to maintain some relationship in case something ever arose, some kind of emergency, and I believe that. But, typically I am using herbal and holistic cures to self-treat myself.

And some participants only went to the doctor because they were required to do so in order to maintain their health insurance and/or government health subsidies. As explained by Molly, who had not seen a doctor for 35 years prior to getting Medicare, “I don’t really go to the doctor. Except, to get Medicare I had to have a doctor and I didn’t even have one. So I just had to choose one. You have to have a baseline test or something done.”

The place of Western medicine

No participants indicated that they were wholly against the use of Western medicine. Rather, participants generally agreed that there was a place for Western medical treatment, such as to

treat emergency conditions characterized by sudden onset (such as traumatic accident injuries, broken bones, heart attacks, or strokes), to treat chronic or severe pain, and to treat conditions that can worsen and become life threatening (such as by using antibiotics to treat internal infections and Lyme's disease). For instance, Morgan and Bob explain how Western medicine is useful for emergency situations:

I think that conventional medicine definitely has its place, absolutely. But I just feel like I know more in terms of my care on the everyday things. Certainly, if I needed surgery or if I was an accident, I would turn myself over to their expertise. But in day-to-day maintenance of my health I think I know better, I feel sovereign in that.

Who knows, if I had a heart attack or something, that's when allopathic medicine does its job really well. Things that come on suddenly: strokes and heart attacks, sudden injuries, you know, that sort of thing. They go into action and they put whatever drugs in you and they save people a lot of times. But, I think that if you're living a fairly healthy lifestyle, those things are going to happen probably a little less often.

And, as explained by Andrea, "Whatever I'm dealing with, if it gets to the point where it's getting out of hand or I'm escalating it, then I would go to the doctor, go the Western, as a last, last thing to try." And for Bob, "Let's say I'm feeling a lot of pain or something. I wouldn't go to a doctor, I would stretch or do yoga before I did that. If it was something terrible then I might go see someone, like maybe I've got a broken foot or something."

Participants largely viewed the use of Western medicine as a last resort, as an option after the use of herbal medicine and other CAM therapies was deemed a poor fit to treat their condition or failed to successfully resolve a health issue. Few participants indicated the concurrent use of prescription medications, while most participants indicated that they would take a prescription medicine if they really needed to. Some participants indicated the use of over-the-counter pain relievers, such as ibuprofen and aspirin, if, for example, headaches or menstrual cramps were

severe enough to interfere with their day-to-day functioning and remained unrelieved by other natural therapies. As described by Angie, “I don’t really use any medicine, if something was really bad, like if I had really bad cramps or something, I’d maybe take an aspirin. But I try to avoid anything.” And for Zoe, “the only time I use ibuprofen or aspirin or something like that is for pain. ... If I had chronic pain from arthritis, I’m not sure how I would approach it. I would try herbals first. But pharmaceuticals have their place, definitely, but it’s not the first thing I reach for, ever, at all”

In summary, the vast majority of participants indicated that their use of herbal medicine and other natural therapies was their “first thought” and “first choice” when it came to treating illness; but that they would utilize Western medicine if there was a need to do so. Some participants regularly utilized Western medicine in an integrative fashion, while others actively sought the regular use of Western medicine as a means of diagnosing and preventing emergent illness, and yet others only regularly consulted with herbal medicine because their health insurance required that they do so. Participants generally agreed that Western medicine was a good fit for sudden, traumatic injuries and illness, chronic or severe pain, and when they believed that herbal medicine was unable to effectively treat a health condition.

Boundaries between Herbal and Western Medicine

While only a few participants desired to see a Western medical doctor, many participants indicated a preference for seeing medical practitioners that were holistically inclined, CAM-friendly, and integrative in their approach. When I asked participants if they experienced particularly negative encounters with doctors with regard to their concurrent use of herbal medicine, participants characterized their doctor’s response to their use of herbal medicine along

a spectrum from informal guidance and support of their use of herbal medicine, to an ambivalence about their use of herbal medicine, to feeling a need to defend their choice to use herbal medicine.

While many participants who were able to recount the quality of previous Western medical encounters indicated that their doctors respected their choice to use herbal medicine, a few participants described experiences where their doctor went out of their way to provide informal guidance about the use of herbal medicine. As recounted by Steven:

I had a doctor who heard my stories and what I do. They always asked what I take and I like the herbs I take, you know, and they ask me why I am doing these [herbs] and stuff, and she didn't say anything the first time I saw her. She just said, 'Oh, you should come back next month and see me again.' So when I came back she said, 'Just a minute.' And she went back to her office and she had a little package of paperwork for me. She said, 'Here, I got this for you.' And it was about herbal treatment for my problems. She was very supportive. But she said, 'This is between you and me, but this is what I think right here.'

When it comes to providing a list of all the herbal medicine that participants used for their doctor's review, some participants characterized their doctor's response to their use of herbal medicine as ambivalent and/or non-existent. For instance, Mary described how her doctor "didn't say anything... he was just, no comment," and Theresa describes how her gynecologist doesn't ask any questions about her use of herbal medicine presumably because she doesn't know how to use herbal medicine:

And every time they're like, are you taking any supplements? And I say, 'Yes, I'm taking Chinese herbs.' And then they don't ask any questions because they don't know what to ask, they don't know anything about Chinese herbs. So I'm super honest about it. But, they wouldn't know what to do with the information. If they [medical doctors] were like, 'What are you taking,' and I told them, it wouldn't mean anything to them.

When it comes to participants' negative perceptions of their doctor's response to their use of herbal medicine, some participants described difficulties finding a medical doctor who would

support their choice to not vaccinate their child and the perception that their doctors “shunned” them or were condescending. Further, some participants indicated that they discontinued seeing medical doctors or stopped disclosing their use of herbal medicine to medical doctors in order to avoid negative responses to their use. For example, Betty described her hesitation to seek consultation with a medical doctor because she didn’t “want that look that they give you, like you have three heads, whenever you want to talk about, I want to take my herbal stuff instead.” And Monica described how her perception of doctors’ negative responses to her use of herbal medicine led her to stop disclosing her use of herbal medicine to doctors.

...every time I go to see a medical doctor and I mention my use of herbs or my interest in herbs, the common reaction is to condescendingly talk down to me about how I really shouldn’t be using that, or how that doesn’t work, or just not acknowledging that they actually may have some sort of effect with regard to why I am taking them. ... I found that medical doctors are not very open to it, and they automatically assume that it’s not something that really has much science behind it, which is actually very untrue. So a lot of times they’ll try to talk to me in a way that is technical, thinking that I’m not really going to understand... So I don’t know, I just kind of stopped talking to them about it.

And, a couple participants lamented their inability to find a Western medicine doctor who embraced an integrative approach. For instance, as noted by Maggie in response to whether she sees a Western medical doctor, “No, in this area it’s hard to find one that bridges the gap, which is what I’m looking for.” At the same time, most participants took care not to personally blame Western medical practitioners for their inability to be more integrative in their approach to healing. Instead, they referred to how doctors receive little training in the use of herbal medicine, there are few reliable scientific studies demonstrating the efficacy of herbal medicine for doctors to draw expert knowledge from, the medical profession is dominated by corporate interests, and doctors may fear professional repercussions for recommending treatments that are outside of their professional training and expertise. For example, Carol described how the medical community’s “hands are tied because there’s not enough evidence-based research, they

[herbal medicines] are not FDA approved, so they [medical doctors] can't really steer you in that direction and get paid by insurance and stuff like that." And Theresa described how doctors may be persuaded to prescribe pharmaceutical medications because pharmaceutical companies reward doctors for prescribing their product, as well as how some doctors resist the pharmaceutical industry's pressures.

It's not to say that there aren't good doctors out there who didn't go into the medical profession because they really wanted to help people. But there is a lot of corruption in the industry and there is a lot of pressure from pharmaceutical companies, that they will get certain kickbacks for using this drug or that drug and over a period of time you can rationalize different things in your mind to make it okay to do the things that you do. There are actually many doctors who, once they got into this and saw the damage the drugs were doing, said, 'this is not right, this is not really helping people.' And that's when they either totally gotten out or somehow they became an integrative kind of MD trying to incorporate the natural in with some of what they do.

Steven described how doctors are confined by the boundaries of Western medical knowledge and held accountable if any deviations from the Western medical canon produce undesired effects.

They [doctors] run the gamut. You know, some of them are absolutely locked into what they learned in medical school and they can't get off that, they won't for a moment change their point of view because they're afraid to think to do that. You know, obviously if they say, 'take cranberry juice,' and you die well then, maybe they got a problem you know. So they're afraid to do that. As long as they follow their purview, they're protected. And that's a really sad situation about our society, that we're so litigious and everyone wants to blame the doctor. So they [doctors] shield themselves behind their training.

These findings suggest that participants believed that doctors had good intentions, but were susceptible to the pharmaceutical industry's influence and the confines of Western medical knowledge. Further, participants generally indicated that their doctors "ran the gamut" from being supportive, to ambivalent, to judgmental about their use of herbal medicine, whereby the latter sometimes functioned as a deterrent to telling their doctor about their use of herbal medicine. In addition, these findings indicate that many participants desired more reliable

information to guide their doctor's awareness of herbal medicine as well as a more integrative approach to illness and health in Western medicine.

Obstacles to Herbal Medicine Use

Some participants identified difficulties and obstacles to using herbal medicine, including a lack of accessible reliable information to guide their personal use of herbal medicine, a lack of health insurance coverage for herbalist consultations and herbal medicine, and a lack of resources (e.g., time and money) to devote to the practice of herbalism in everyday life. Accordingly, many of these participants voiced the desire for more scientific research on herbal medicine so that they would have more reliable information about the use of herbal medicine to guide their use and increased health insurance coverage of herbal medicine and herbal practitioners. For instance, Carol described her desire for more research on herbal medicine as well the need for more funding to support this research:

...I would love to see more research done into the specificities of using herbal medicine. I would love it as an American citizen. I mean, there are all kinds of studies on St. John's wort coming out of Germany. But as an American, I would love to have more information and figuring out ways to fund research into herbal medicine because [I was] blindly being kind of guided.

And Glen invoked a holistic understanding of medicinal plant effects to describe difficulties in scientifically validating the medicinal effects of herbal medicine, including the inadequacy of evidence based research to accurately measure the efficacy of medicinal plants, the lack of funding for research, and concerns with regard to the interests of research funders.

It's hard to know how healthy all that stuff is because nobody's doing studies on it. Just to do a scientific study is so complex. In scientific studies they try to simplify it down to like one thing. The thing is plants have multiple items, and once you go from 2 to 3 to 4 to 5 or more it makes a study so much more that our regular scientific studies cannot deal with that with the complexity. So I think our whole scientific establishment has to learn how to deal with the multi-factorial

studies... Our whole scientific establishment is corrupt to begin with because funding sources many times are not disclosed. And if we really want to have objective science, we've got to separate the funding source from the study itself, and were not doing that now, because so much of the studies are just political or commercial interest.

Further, some participants referred to the active suppression of herbal medicine knowledge, such as knowledge from texts, from herbal product labels, and from herbalists. These participants referred to the profit motive underlying the medical and health insurance industries in tandem with FDA regulations on herbal medicine indications on product labels and licensing laws that prohibit herbalists from "practicing medicine." For instance, Morgan discussed how the pharmaceutical industry influences FDA regulations prohibiting the indication of medicinal effects on herbal product labels.

The FDA is basically a lackey for the pharmaceutical industry by far. If you do any sound investigation typically you will come to that conclusion, and I have definitely come to that conclusion many times over. What they force the whole herbal and supplement industry to do pretty much, is they can't make medicinal or curative claims about your products. And that's done by design to keep the public from being able to connect the dots.

And Tory voiced discontent with the 2010 Affordable Care Act requirement that everyone either carry health insurance or pay a fine because she didn't use her health insurance. Accordingly, Tory felt like she was paying for other people's reliance on Western medical care.

Of course with this new Obama healthcare, it obsoletes alternative health. And I pay \$200 a month out of my social security for other people's medicine. I have no choice in doing that. If I refuse to let that money come out, then they fine me \$150 because I don't have mainstream healthcare. I don't use medicine so I'm paying for somebody else's not taking responsibility for their health. And so this is so wrong on so many levels, you know, an extra \$200 would buy me a lot of herbs. (laughs) So, it's a shame because people will go to mainstream rather than go to the herbs because Medicare or Medicaid or something will pay for it, it's all their insurance will pay for, and no one is paying for correct healthcare.

Glen also describes how, due to health insurance not covering herbal medicine, the out-of-pocket cost of herbal medicine can act as a deterrent to seeking professional guidance on the use of herbal medicine

When you're going an alternative route, you have to pay for everything yourself, you know, because the insurance companies, which are also controlled by the medical establishment, they don't pay for alternative of treatment. Maybe they're beginning to do so a little bit. But when you do go for alternative methods you have to pay for that out-of-pocket. And so if you have limited funds you have to conserve who you go to see. So you can't go see everybody at once. (Glen)

Thus, in addition to concerns about the power of the pharmaceutical industry to garner the public's trust and faith in pharmaceutical medicine, some participants also voiced concerns with regard to how the pharmaceutical industry wields its political influence to suppress information about herbal products' medicinal uses. In addition to barriers to knowing how to use an herbal product without indications for its medicinal use on product labels, some participants described how the lack of health insurance coverage for herbal medicine presents a barrier to both their, and the public's, use of herbal medicine.

CONCLUSION

In this chapter I described how three-quarters of the participants in this research experienced a situation, such as chronic illness, injury, becoming pregnant, or being without health insurance, and believed that herbal medicine was safer, more effective, more accessible, or a better fit for use in that situation. Participants who experienced illness considered, and in many cases initially used, Western medicine to treat their condition but developed dissatisfaction with the Western medical approach to their ailments following Western medical encounters. Many participants who began using herbal medicine in response to a health need did so to treat cancer, a contested

illness, or for additional nourishment while pregnant. This finding provides some evidence that herbal medicine may be perceived as a better fit for some health conditions.

Further, participants indicated different types of dissatisfaction that varied by the reason that they began using herbal medicine. Participants who used herbal medicine to treat cancer did so because of an unwillingness to accept a cancer diagnosis and its corresponding poor prognosis as constructed by Western medicine; the perception of poor doctor-patient communication, such as when the doctor was perceived as rude, as instilling fear, and when medical doctors were unable to provide acceptable answers with regard to participants' condition and treatment; and out of concern about the risks of Western medical treatment for their condition. On the other hand, participants thought to be suffering from contested illness grew dissatisfied with the perceived inability of the Western medicine to accurately diagnose and/or effectively treat their condition. These findings suggest that forms of dissatisfaction stemming from Western medical encounters may vary by the types of health needs that prompted participants to seek Western medical care.

Many participants who started using herbal medicine to treat an illness identified no pre-existing interest in herbal medicine. Upon experiencing illness and developing dissatisfaction with Western medical approaches to diagnosing and/or treating their illness, these participants actively sought information on alternative therapies. Only a couple participants who sought herbal medicine to treat an illness had an interest in or knowledge about the use of herbal medicine prior to their illness experience. While their interest in herbal medicine exerted some influence, the illness experience and concomitant forms of dissatisfaction with the Western medical approach to their illness exerted the largest influence upon their choice to learn about the use of herbal medicine for their specific condition.

Participants who started using herbal medicine to treat an illness indicated some different and more varied knowledge sources than those who began using herbal medicine for other reasons. In addition to the influence of family, friends, and texts indicated by many participants, participants who sought the use of herbal medicine to treat an illness also cited the influence of health food and herb store employees, CAM practitioners, herbal product manufacturers, and others encountered during the illness experience. Further, some participants described how lucky they were to have met people during their illness experience who recommended the use of herbal medicine, which suggests their valuation of this happenstance transmission of knowledge during a time of perceived need for that knowledge.

Whereas participants who were drawn to herbal medicine by way of an interest cultivated from experiences and social influences throughout their life course described their affinity for reading and learning, participants who sought information on the use of herbal medicine to treat a specific health condition more often referred more to their research skills. For example, participants who indicated their initial use of herbal medicine to treat an illness referred to themselves as a “natural researcher,” as being “good at research,” and as a “library buff.” This difference suggests that participants draw upon different personal skills and aptitudes with regard to finding information on the use of herbal medicine depending on whether they first sought knowledge on the use of herbal medicine primarily out of an interest in herbal medicine use or to treat a specific condition.

Some participants believed that herbal medicine was more accessible and/or a better fit than Western medicine, particularly while without health insurance. In these cases, participants indicated that they used herbal medicine as a “proactive insurance” to maintain their health and to treat emergent ailments so as to prevent the need to use herbal medicine (see Egan et al. 2011).

Similarly, participants who began regularly using herbal medicine while pregnant and child rearing believed that herbal medicine was a safer and more natural alternative to chemicals and pharmaceutical medicine, echoing widespread concerns about pharmaceutical use during pregnancy.

This research found that nearly all of the participants who turned to herbal medicine more out of the fit and accessibility of herbal medicine (i.e., those who were pregnant or without health insurance) had a pre-existing interest in herbal medicine stemming from childhood influences and experiences and accumulated varying levels of herbal knowledge and experience throughout their life course prior to experiencing these situations. Childhood experiences in nature and their family's use of herbal medicine led these participants to seek and be receptive to knowledge about its use from texts, their child's father and his family, midwives, peers, and CAM practitioners upon becoming pregnant or being without health insurance during adulthood. These participants largely used herbal medicine for additional nourishment and to maintain their health in an effort to prevent the need to use Western medicine so as to mitigate the risks and costs associated with its use. In contrast, participants who turned to herbal medicine to treat chronic illness indicated that they did so more out of dissatisfaction with Western medical treatments for their condition.

The findings presented in this chapter indicate that many participants wanted to have more responsibility and control over their health, a desire that seemingly stemmed from holistic beliefs with regard to health and illness and a belief in instinctual knowledge. Some participants' desire for more control and responsibility over their health manifest by maintaining positive thinking in the face of fears, both within themselves and voiced by their doctors and family, with regard to their illness and prognosis; in seeking to get to the root cause of their illness so that they can find

relief that Western medicine was unable to provide for them; in seeking to maintain their health in an effort to avoid using Western medicine; and in wanting to develop and raise healthy children who were not unnecessarily subjected to Western medical interventions.

All but one participant voiced varying degrees of concern about the safety and efficacy of pharmaceutical medicine and the overuse of pharmaceutical medicine that exerted varying degrees of influence upon their use of herbal medicine. Firstly, many participants believed that pharmaceutical medicine was less safe and effective than herbal medicine, in part because pharmaceutical medicine had side effects that were characterized as more harmful than the illness they were prescribed to treat and because pharmaceutical medicine synthetically derived. Secondly, many participants believed that pharmaceutical medicine was overused, a belief that often stemmed from distrust in the profit-motive of the pharmaceutical industry and its power to sustain the public's dependence upon and trust in Western medicine by way of medicalizing disease, advertising, maintaining (rather than curing) disease, and via its institutional embeddedness in American society. The findings presented in this chapter indicate that concerns about the safety and efficacy of pharmaceutical medicine were especially salient among women during pregnancy and child rearing, while concerns about the pharmaceutical industry's role in the public's overuse of pharmaceutical medicine were most salient among participants who observed others' dependence upon pharmaceuticals and/or developed political attitudes by way of the influence of social movements.

All participants in this research indicated a strong preference for herbal medicine over pharmaceutical medicine, whereby they used herbal medicine to maintain their health and to treat acute pain, injuries, and chronic conditions. A quarter of participants still sought regular Western medical care in order to maintain an integrative approach to their health, for diagnostic

and preventative care, to maintain a partnership with a medical doctor in case a need arose for Western medical care, and because their health insurance required that they receive Western medical check-ups. Further, participants indicated that Western medicine does have a place, particularly in the case of sudden or traumatic illness or injury, to treat chronic pain, and as a last resort when their use of other treatments did not effectively treat their ailments.

Participants also indicated obstacles to their use of herbal medicine. These included a lack of reliable information to guide their use of herbal medicine, a lack of professional support and guidance for their use of herbal medicine, a lack of health insurance coverage for herbal medicine, and a lack of personal resources (e.g., time and money) to practice herbal medicine as fully as they desired. Further, while some participants indicated that their medical doctors reacted negatively to their use of herbal medicine, many did not blame individual medical doctors for their inability to integrate the use of herbal medicine in their practice. Instead, participants often referred to the role of industry in suppressing information about the use of herbal medicine, political regulations governing the practice of herbal medicine, the lack of reliable scientific information on herbal medicine use to inform medical practitioners, and a lack of Western medical training on the use of herbal medicine in maintaining the boundary between the practice of Western and herbal medicine.

These findings suggest that many participants did not wholly reject Western medicine. Rather, many participants indicated varying degrees of the desire for a more integrative approach in Western medicine characterized by increased respect and support for their choice to use herbal medicine, which in many cases stemmed from a desire for medical doctors to value the medicinal potential of plants and to offer more guidance about the use of herbal medicine. This in turn reflects many participants' desire for a greater availability of more reliable scientific information

to guide the use of herbal medicine, increased medical training on the use of herbal medicine, limitations on the pharmaceutical industry's influence on medical doctors, greater insurance coverage of herbal medicine, and a loosening of regulations regarding doctors' liability with regard to recommending herbal medicine.

Chapter 5: Discussion and Conclusion

INTRODUCTION

In order to contribute to the small body of research in the Sociology of CAM that seeks to understand why American adults are increasingly using CAM, I sought to understand why and how current herbal medicine users first began using herbal medicine. To this end, I intensively interviewed 28 daily herbal medicine users' in Cincinnati, Ohio and St. Louis, Missouri to solicit accounts of the process by which they first began using herbal medicine. I questioned how herbal medicine users learned about, became interested in, and chose to use herbal medicine. In particular, I explored how social, cultural, personal, and situational factors uniquely combined to influence herbal medicine users to first begin using herbal medicine. Secondly, I sought to delineate the order in which participants experienced these influences, as well as the relative degree of influence that each had upon participants' choice to begin using herbal medicine.

The findings discussed in chapter 3 and 4 suggest a general process of beginning to use herbal medicine: An interest in and knowledge about herbal medicine grew in a dialectical relationship whereby participants became interested in the use of herbal medicine, which in some cases was concomitant with learning how to use herbal medicine, and in all cases led participants to seek knowledge on the use of herbal medicine. As participants learned more about herbal medicine, their interest in learning more about the use of herbal medicine grew. When participants first used herbal medicine and found it effective for its intended purpose, participants' interest in herbal medicine continued to grow in tandem with further knowledge seeking, which in turn led them to begin regularly using herbal medicine.

Where participants diverged in this basic process was in where they started on the path to first using herbal medicine and in the order they experienced different influences along the path. Two-thirds (68%) of the participants in this research first developed an interest in and acquired varying degrees of knowledge about herbal medicine throughout the life course; while the rest (32%) of participants first experienced a health need. The findings of this research indicate that participants took three distinct paths to using herbal medicine: A quarter (25%) of participants who started with an interest in herbal medicine began using herbal medicine out of a general interest in its use. Over a third (42%) of participants with an interest in herbal medicine did not begin using herbal medicine until they experienced a situational circumstance that prompted its use. And, a third (33%) of participants first experienced a specific health need that led them to seek and/or be open knowledge about and develop an interest in the use of herbal medicine to treat their condition.

SUMMARY OF FINDINGS

Three Paths to Using Herbal Medicine

Many participants first developed an interest in the use of plants for medicine following social and cultural influences and experiences with nature and herbal medicine during childhood.

Some of these participants described how experiences playing in nature and with plants during childhood cultivated a connection with nature and plants that led them to value nature; while other participants described how the use of herbal medicine by their family, such as by their parents during their childhood and their ancestors' traditional use of herbal medicine, cultivated an awareness of and respect for the use of plants for medicine. A few other participants described how they developed an interest in other CAM modalities during their teenage and early

adult years. In all of these cases, participants' valuation of nature, awareness of and respect for the use of plants for medicine, and interest in CAM, alongside varying degrees of experiential knowledge about the use of herbal medicine and, in some cases, varying degrees of concern with pharmaceutical medicine, cultivated an interest in the use of herbal medicine.

In turn, this general interest in herbal medicine led many of these participants to seek and/or be open to additional influences and knowledge about its use during adulthood, such as by reading texts, working on farms and in health food and herb stores, talking to peers, participating in sub-cultures associated with social movements, and practicing other CAM therapies. The dialectic of increasing interest and knowledge seeking throughout early-mid adulthood, in some cases in tandem with emergent concerns about the public's overuse of pharmaceutical medicine stemming from distrust in the profit-motive underlying the unsustainable operation of the pharmaceutical industry, led a quarter of participants to begin using herbal medicine out of interest in its use.

On the other hand, a third of participants did not develop an interest in the use of plants for medicine until after they became ill or injured and grew dissatisfied with the Western medical approach to their illness or believed that herbal medicine was more accessible than Western medicine. In these cases, participants sought or were offered information about CAM treatments for their condition, became interested in the use of herbal medicine to treat their condition, and then began using herbal medicine to treat their condition. Upon finding herbal medicine effective in treating their condition, these participants grew more interested in learning about its use, and then began regularly using herbal medicine.

Other participants cultivated an interest in the use of herbal medicine throughout the life course, but did not begin regularly using herbal medicine until they encountered a situation that prompted its use. These participants included some women who became pregnant or did not have health insurance and a couple men who became ill or injured, all of whom believed that herbal medicine was safer, more effective, more accessible, or a better fit for treating their condition and/or maintaining their health than Western medicine.

These findings indicate that participants tread one of three paths into their use of herbalism: some began with an interest in herbalism and began using herbs out of a general interest in its use; some began with an interest in herbalism but did not begin using them until they encountered a situation that prompted its use; and others first experienced a health need during which they developed dissatisfaction with the Western medicine approach to their ailments and sought alternative therapies, which led them to begin using herbal medicine to treat their condition. These findings also indicate that varying degrees of interest in and knowledge about the use of herbal medicine precede the use of herbal medicine.

Further, these findings suggest that a general interest in herbal medicine was initially cultivated by social and cultural influences and experiences with herbal medicine during childhood and early adulthood, or out of an interest in CAM to treat a particular health need during adulthood; while for others a more specific interest in herbal medicine emerged during an illness or injury experience. In some cases, participants' interest in using herbal medicine emerged from both influences and experiences during childhood and experiencing a situational condition as an adult. Participants whose interest in herbal medicine was cultivated early in life learned how to use herbal medicine by way of their family's use during childhood, texts, work experiences, peers, and CAM providers. On the other hand, participants whose interest in herbalism stemmed from

an interest in CAM treatments for a health condition largely indicated learning about its use from texts, CAM providers, health food and herb store employees, and others encountered during the illness experience.

Salient Influences

Participants who began using herbal medicine out of a general interest in its use most often cited the influence of texts and experiences working with herbal medicine as the most important upon their choice to begin using herbal medicine, followed by the influence of peers, CAM practitioners, and social movements. This finding indicates that learning how to use herbal medicine is very important in the process of using herbal medicine. Most participants whose interest in herbal medicine was cultivated throughout childhood did not see these early influences and experiences as particularly influential on their choice to use herbal medicine as adults. This finding suggests that these participants' interest in herbal medicine was largely taken-for-granted as a part of their self-concept and/or personality.

In contrast, participants who began using herbal medicine because they became ill, injured, pregnant, or were without health insurance overwhelmingly cited the experience of these situations in concert with beliefs and attitudes about Western medicine as the most salient influence upon their choice to begin regularly using herbal medicine. Many participants who had a pre-existing interest in herbal medicine prior to encountering a situational condition indicated that learning about its use was of secondary importance, followed by the influence of social and cultural influences and experiences with herbal medicine throughout the life course that cultivated an interest in its use, upon their choice to begin using herbal medicine.

The majority of participants in this research indicated concerns about the safety and efficacy of pharmaceutical medicine and its “overuse” in American society. Reflecting general medical practitioners cautions against taking pharmaceutical medicine during pregnancy, concerns about the safety and efficacy of pharmaceutical medicine were especially salient influences upon participants’ choice to begin using herbal medicine while pregnant. Concerns about the overuse of pharmaceuticals, particularly those stemming from the profit motive underlying the unsustainable operation of the pharmaceutical industry, were especially important influences upon a few participants’ choice to begin using herbal medicine out of a general interest in its use, whereby they indicated using herbal medicine as a means of living a more sustainable lifestyle. Other participants’ concerns about pharmaceutical medicine were largely indicated outside of their account of how they first began using herbal medicine; thus, it is unclear whether their beliefs and attitudes about pharmaceutical medicine precipitated, or followed, their choice to begin using herbal medicine. In any event, concerns about pharmaceutical medicine were important in many participants’ choice to continue using herbal medicine following their initial use.

DISCUSSION

Cultivating an Interest in Herbal Medicine

No previous research has sought to understand how people make the choice to begin using herbal medicine. This research contributes an understanding of the process by which 28 current regular herbal medicine users first began using herbal medicine. As discussed below, the findings of this research largely support previous research that identified factors that correlate with CAM use and academic speculation and theorizing about the impact of social structural changes upon the

increase in CAM use in recent years. In addition, this research complements existing research with a detailed, in-depth qualitative understanding of how these factors are experienced by people in different sequences and in varying degrees of influence during the process of starting to use herbal medicine. However, there are some discrepancies between the findings of this research and previous research that largely stem from the primary focus in this research on why and how people choose to begin (as opposed to continue) using herbal medicine (as opposed to CAM in general or other specific CAM therapies). In this section I will situate the findings of this research within broader theoretical frameworks advanced in the effort to understand why and how people use CAM.

Previous research, most of which is survey-based, has advanced two broad overlapping theoretical frameworks to explain why people use CAM: the postmodern thesis and the push-pull model. The findings of this research confirm the influence of many factors identified in these theoretical frameworks and contribute an understanding of how the presence and degree of influence of these factors vary among the three different paths in the process of beginning to use herbal medicine. I conclude that each of these frameworks offer only a partial understanding of the process by which participants in this research began using herbal medicine.

The following discussion is organized by the main themes of these theoretical frameworks, whereby I describe the frameworks and discuss how they shed light on the findings of this research, as well as how the findings of this research support, complement, and extend previous research so as to come to better understanding of why and how people make the choice to use herbal medicine. I also draw upon other survey research, qualitative research, and speculative theorizing to shed more light on how the findings of this research support and extend the larger body of research that seeks to understand why and how people use CAM. I discuss the

significant contributions of this research to the larger body of extant research throughout the following.

Postmodern thesis

Mitchell and McClean (2014; see also Mitchell 2010) invoked the concept of reflexive modernity to explain how pregnant women in their study believed that herbal medicine was safer and gentler to use in response to risks associated with pharmaceuticals and technological interventions during pregnancy. Beck's (1992) classic formulation of manufactured risk in late modernity refers to the preponderance of risks we see resulting from industrial and technological advances, such as risks relating to climate change and nuclear disasters stemming from advances in energy production, or risks associated with the consumption of genetically modified foods. Concerns about such risks reflect a social state of reflexive modernity, whereby people recognize the limits and contradictions of modern institutions, resist the authority of modern institutions, and reevaluate the technological advancements of modernity with the prevention of risk in mind (Beck 1992; see also Branson 2014; Giddens 1990; Lyng 2010). In much the same way that people store emergency food, water, and other resources in efforts to be prepared in the event of natural or man-made disaster, or exercise and diet in an effort to prevent heart disease, participants' use of herbal medicine may be seen as a way to avoid the risks associated with pharmaceutical use.

Reflexive modernity presupposes an increasing awareness of and reaction to the risks associated with the institutions of early modernity contained within a later stage of modernity, wherein defining features of modern society (e.g., capitalism, science, and mass democracy) persist (Beck 1992; Giddens and Pierson 1998:115-117). In contrast, some scholars propose the emergence of

a new postmodern social order during the late 20th century characterized by a new belief system that, due to globalization and hybridized value and belief systems, is characteristically different from modern belief systems (Bakx 1991; Coulter and Willis 2004; Giddens 1990:46). In postmodern society, people are led to critique the byproducts of modern industrial growth and question the authority of modern science. At the heart of postmodern society is a loss of faith in the ability of modern institutions to solve the problems that those institutions caused. Some scholars attribute the beliefs and values that influence people to use CAM to the emergence of a postmodern value system (Astin 1998; Bakx 1991; Coulter and Willis 2004, 2007; O'Callaghan and Jordan 2003; Siahpush 1998).

The postmodern thesis proposes that people use CAM because they are open to new experiences, have an interest in and curiousness about the natural world, and value nature, where nature is viewed as manipulated and polluted by the growth of profit-driven modern industry. Anti-technology and anti-science sentiments emerge, whereby technology and science are seen as degrading the environment, tampering with nature, and creating invasive and potentially harmful medical interventions. Dissatisfaction with modern medicine emerges from concerns about the synthetic, chemical nature of pharmaceutical medicine, the public's overreliance on pharmaceutical medicine, iatrogenic illness, and the invasiveness of medical treatments. The result of this is that people are increasingly driven to question the authority of modern medicine, which leads people to seek greater levels of control and responsibility over their health, such as by self-help and holistic means of maintaining the health. Further, as the authority of organized religion declines, spirituality and intuition emerge as correlates of CAM use (Coulter and Willis 2007; Fries 2003).

Whether we live in a period of late modernity or have entered into a postmodern state, nearly all participants in this research discussed beliefs and values that are congruent with both a state of reflexive modernity (Beck 1992; Branson 2014; Giddens 1990) and the postmodern thesis proposed to explain why people use CAM (Bakx 1991; Coulter and Willis 2004, 2007; O'Callaghan and Jordan 2003; Siahpush 1998). The findings of this research contribute an understanding of how some participants cultivated these values and beliefs and how these values and beliefs influenced their choice to begin using herbal medicine.

All participants indicated some degree of spirituality, whereby most participants indicated that they were very spiritual (see Appendix K). And, some participants indicated a valuation of nature that oftentimes stemmed from experiences playing in the natural world during their childhood during which they developed a connection with nature. However, most participants did not indicate that their spiritual beliefs and valuation of nature were salient influences on their choice to begin using herbal medicine; rather, these beliefs and values influenced participants' interest in herbal medicine, which later influenced them to learn more about herbal medicine.

Many participants also indicated concerns over the safety and efficacy of pharmaceutical medicine. Yet, many of these participants also believed that herbal medicine could produce unwanted effects, but that these effects were less prevalent and less harmful than adverse effects arising from pharmaceutical use, particularly if herbal medicine was used correctly. These concerns were especially salient in some participants' choice to begin using herbal medicine while pregnant, whereby participants believed that herbal medicine was safer to use during pregnancy. These findings support previous research indicating that herbal medicine users believe that herbs are generally healthy and safe to use (Carisle 2003; Cushman 2008; Egan et al. 2011; Nissen and Evans 2012); as well as research finding that pregnant women may use herbal

medicine as a safer and more gentle alternative to pharmaceutical medicine (Holst et al. 2009; Mitchell and McClean 2014; Pole et al. 2000; Vickers, Jolly and Greenfield 2006; Westfall 2003). Interestingly, most participants who used herbal medicine during pregnancy indicated its use to provide additional nourishment for their growing baby rather than as an alternative to pharmaceuticals to treat a particular ailment. This motivation for using herbal medicine during pregnancy is under-examined in extant research on the use of CAM during pregnancy (Adams et al. 2009b).

Many participants also described concerns about the overuse of pharmaceutical medicine stemming from distrust in the profit motive of the medical industry. Yet, only a few participants indicated that these concerns about pharmaceutical medicine were particularly important upon their choice to begin using herbal medicine, particularly when they used herbs out of an interest in its use and/or in an effort to live a more ecologically sustainable and politically correct lifestyle. In addition, many mothers voiced concerns about the overuse of pharmaceutical among children, which in part fueled their choice to administer herbal medicine for their children. Often times, these participants' concerns emerged from observing their child's classmates and their clients' at health care related work places overreliance on pharmaceutical medicine, as well as, for some, from political beliefs influenced by social movements.

While an affinity for "green movements," such as health, food, and environmental movements, is indicated in the postmodern thesis, some participants referred to participation in movements that revolved around political and economic concerns (e.g., the 1960s hippie movement and the recent Occupy movement). This indicates that these participants' choice to begin using herbal medicine was, in part, politically-motivated. While Pawluch et al. (2000) found that some HIV patients used CAM in part because they "had trouble with Western medicine as an institution,"

this motivation stemmed from discomfort during Western medical encounters that reflected their participants' stigmatized identities (i.e., intravenous drug users and gay men who had contracted HIV/AIDs), conditions that did not seemingly apply to participants in this research.

Some participants referred to learning by intuition and instinctual knowledge, a way of knowing that correlated with their respect and affinity for the Native American and Midwife herbal traditions in America, whereby these herbal traditions are known to embrace this form of knowing (Gladstar 1993; Weed 2001). These participants indicated that this instinctual knowledge manifested as a means to connect with plants, a desire to avoid chemicals while pregnant, and to inform some mothers' decision on the best course of treatment for their infant child.

Further, some participants indicated an emergent interest in and curiosity about other CAM therapies during early adulthood that gradually evolved to encompass herbal medicine. This finding seemingly supports previous research indicating that an interest in CAM can lead to the use of CAM (Caspi et al. 2004; Kelner and Wellman 1997; Sirois and Gick 2002). Some of these participants described how their interest in CAM transferred into an interest in learning about the use of herbal medicine, while other participants described how their use of other CAM therapies exposed them to the use of herbal medicine, which then led to their interest in learning more about herbal medicine.

The postmodern values and beliefs discussed above were most often indicated by participants who cultivated an interest in herbal medicine during childhood and early adulthood and began using herbal medicine out of a general interest in its use or to prevent the need to use Western medicine while pregnant or while without health insurance. Yet, concerns about pharmaceutical

medicine aside, most participants did not indicate that these values and beliefs were particularly important when making the choice to begin using herbal medicine. Instead, participants largely described these postmodern values and beliefs as a part of their self-concept, which was often seen as secondary to the importance learning how to use herbal medicine. Participants who had a general interest in herbal medicine but did not begin using herbal medicine until prompted by a situational condition largely cited the situational circumstance as the most salient influence upon their choice to use herbal medicine. These findings suggest that the postmodern thesis is helpful in understanding how people to develop a general interest in using herbal medicine, an interest that when combined with learning about herbal medicine and, in some cases, the experience of a situation that is a fit for herbal medicine use, may lead to its use.

The finding that many participants shared postmodern values and beliefs about health and medicine at the time of interview, but that fewer participants indicated that these beliefs and values were present and influential in their choice to begin using herbal medicine, suggests that postmodern values and beliefs may only influence some people to begin using herbal medicine. Some participants who did not identify the presence or cite the influence of postmodern beliefs and values when they chose to use herbal medicine indicated that their interest in herbal medicine stemmed from emergent dissatisfaction with the Western medical approach to their chronic illness. This suggests that postmodern beliefs and values can develop throughout the course of continuing to use herbal medicine. That is, the postmodern thesis may better explain why people continue using herbal medicine than why people make the choice to begin using herbal medicine. This illustrates the importance of distinguishing between the factors that influence someone to start using and those that influence one to continue using CAM.

Push-Pull framework

The beliefs and attitudes associated with the postmodern thesis are also thought to “pull” people into using CAM, while dissatisfaction with Western medicine is thought to “push” people into using CAM (Bishop et al. 2006, 2007, 2010; Kelner and Wellman 1997; Khokher 2009; Vincent and Furnham 1996). As the factors thought to pull one into using CAM and the “push” of generalized dissatisfaction with Western medicine heavily overlap with the beliefs and values associated with the postmodern thesis, they are addressed above. The idea that dissatisfaction stemming from Western medical encounters “pushes” someone into herbal medicine more accurately describes why some participants developed an interest in using herbal medicine to treat a specific illness. As described in chapter 4, participants who first began using herbal medicine to treat chronic illness voiced varying degrees of dissatisfaction stemming from Western medical encounters. Further, some participants voiced a strong sense of frustration with Western medicine’s ability to provide relief for their chronic, contested illness.

However, rather than being pulled or pushed into using herbal medicine, the findings of this research suggest that participants fell along a spectrum of push and pull factors, whereby a quarter of participants began using herbal medicine out of a general interest in its use that in some cases was influenced by varying degrees of concern with pharmaceutical medicine; and some began using herbal medicine primarily because they became dissatisfied with the Western medical approach to treating their chronic illness. In the middle are the largest group of participants who began using herbal medicine because they had an interest in its use and encountered a situation whereby they deemed herbal medicine safer, more effective, more accessible, and/or a better fit than Western medicine.

Thus, while the push-pull model is a useful heuristic for understanding how some people may begin using herbal medicine out of an interest in herbal medicine or out of dissatisfaction with Western medical approaches to their illness, these findings do not support the characterization of participants being pushed or pulled into CAM, particularly when it comes to understanding how many participants had both an interest in herbal medicine and grew dissatisfied or concerned about Western medicine. However, these findings do support other researchers' conclusions that most people begin using CAM because they are both attracted to CAM and deterred from conventional medicine (Bishop et al. 2010; Furnham and Vincent 2003; Khokher 2009). Moreover, these findings reflect MacArtney and Wahlberg's (2014) determination of the helpfulness of understanding "the user of CAM as situated within a multitude of push-and-pull forces, none of which can be said to be explanatory in general, although they might be causally significant for specific instances" (p. 117).

Some research utilizing the push-pull framework additionally incorporates Andersen and Newman's (1973; see also Andersen 1995) model of health care choice (e.g., see Vincent and Furnham 1996; Kelner and Wellman 1997). In this research, different predisposing, enabling, and need factors are thought to intersect in varying configurations to push and pull people to use CAM. Factors associated with the predisposing, enabling, and health need categories in this model overlapped by way of their function in influencing participants to start using herbal medicine use. For instance, predisposing factors, such as the influence of participants' family's use of herbal medicine growing up, not only cultivated beliefs and values that led to an interest in herbal medicine, they also functioned as enabling factors whereby participants indicated simultaneously acquiring varying degrees of experiential knowledge about its use. Further, all

participants indicated the influence of enabling factors, such as the availability of herbal medicine and sources of knowledge about the use of herbal medicine.

While Andersen and Newman's (1973; Andersen 1995) model was analytically helpful in distinguishing among the various factors identified by participants and the function of these factors in participants' use of herbal medicine, the findings of this research largely question the utility of this framework to shed light on how participants began using herbal medicine.

Although Andersen (1995) indicated that this model "suggests an explanatory process or casual ordering" of factors leading one to use health services (pp. 1-2), not all participants experienced predisposing, enabling, and need factors in this order proposed in this framework, and some participants did not encounter a health need that led them to begin using herbal medicine. This may reflect participants' use of herbal medicine as a daily health practice rather than as the utilization of a health service. Thus, this model may be of greater utility to explain how people make the choice to use health services that are provided by a practitioner and utilized in response to a health need.

Dissatisfaction with Western Medicine

The findings discussed in chapter 4 indicate that participants generally cited different types of dissatisfaction with Western medicine that roughly corresponded to the nature of their chronic illness and the character of their corresponding encounters with Western medicine. Some participants, particularly those thought to be suffering from cancer, indicated that they disagreed with their doctor's constructions of their illness and prognosis, perceived little in the way of Western medical treatment options for their ailments, believed the quality of doctor-patient communication was poor, and/or were concerned about the safety and efficacy of the proposed

Western medical treatment for their illness. These forms of dissatisfaction are also indicated in the small body of research that seeks to understand why cancer patients use CAM (Broom and Adams 2009; Hess 2004; Verboef and White 2002; Yates et al. 2005). On the other hand, participants thought to be suffering from contested illness overwhelmingly cited dissatisfaction stemming from the inability of Western medicine to accurately diagnose and/or satisfactorily treat their illness. There is no detectable research indicating how contested illness experiences may prompt one to begin using herbal medicine. Nonetheless, this finding concurs with Overend's assertion that "it is not surprising that many people with chronic undefined disorders turn to complementary and alternative diagnostics as a means of confirming, or at least acknowledging, that which exists outside a strict empirical system" (2014:74).

These findings lend support to previous research indicating that different forms of dissatisfaction with Western medicine correlate with different types of CAM use. For instance, compared to osteopath and acupuncture users, Vincent and Furnham (1996) found that homeopath users were more likely to be influenced by their perception of Western medicine's ineffectiveness; and Kelner and Wellman (1997) found that naturopath users were more likely than acupuncture, Reiki, and chiropractic users to seek the use of this CAM modality out of desperation from Western medicine's inability to provide relief for their condition. As homeopathy and naturopathy both incorporate the use of medicinal plants in their practice, they are arguably the closest CAM therapies to herbal medicine in extant research. As the forms of dissatisfaction uncovered in these studies were also identified by some participants in this research lends support to the idea that different forms of dissatisfaction with Western medicine may correlate with people's choice to begin using different CAM therapies.

Choosing Self-Care

Consistent with both the postmodern thesis and the push-pull model, many participants indicated the desire to have more responsibility and control over their health. This desire was most strongly indicated by participants who invoked beliefs in holism and intuitional knowledge to inform their perception of the safety and efficacy of Western medical treatments for their illness or while pregnant. In addition, a few participants without health insurance also indicated a desire for greater responsibility over their health in order to prevent the need to use Western medicine, and some participants took it upon themselves to get to the root of their chronic illness. In this way, participants' desire for control over their health manifest as a meaningful expression of agency in their motivation to begin using herbal medicine as a form of self-care (Sointu 2006; Broom et al. 2010).

This sense of agency among participants in the face of myriad influences and choices seemingly belays the idea that people are pushed or pulled into using herbal medicine because these verbs imply that participants would have no choice but to use herbal medicine. While nearly all participants voiced some degree of dissatisfaction with or concern about Western medicine, this does not imply that all people who develop dissatisfaction with Western medicine are propelled into using CAM. Rather, the participants in this research are likely among the majority of Americans who lack confidence in modern medicine (Norris 2002; Pescosolido 2006). This finding supports previous speculation with regard to how recent changes in the structure of modern medicine have led to the erosion of patient trust in doctors and a more empowered and engaged public (Jones 2004; Norris 2012; Schlesinger 2002; Siahpush 1999; Timmermanns and Oh 2010; Vuckovic and Nichter 1997).

The findings presented in chapter 4 also provide a deeper understanding of how the desire for greater responsibility and control over one's health emerges and how it manifests. Some participants described an ideological conflict between their doctor's construction of their illness, appropriate treatments, and illness prognosis and their own constructions of illness and health. And some participants indicated that they experienced conflict while making the choice to use herbal medicine that revolved around confronting fears, both within themselves and voiced by others, with regard to the fit and efficacy of herbal medicine to treat illness. In these cases, the desire to have more control over their health stemmed from conflicts with regard to different ideological approaches to health and illness.

The findings of this research suggest that these ideological conflicts stemmed from divergent constructions of the safety and efficacy of Western medical treatments, whereby participants' beliefs in holism and "instinctual knowledge" did not align with Western medical epistemologies underlying notions of safety and efficacy. Holistic beliefs were invoked in participants' desire to think positively about their illness prognosis, to get to the root cause of the illness and effectively cure their illness, as well as to avoid side effects associated with pharmaceutical medicine. In the latter case, participants believed that herbal medicine was safer because it utilized whole plants with pharmacologically active compounds that mitigated adverse effects, but acknowledged that different effects would arise depending on what exactly someone is taking combined with the individual constitution of that person's body. This finding supports previous research indicating that people draw upon holistic beliefs to inform their choice to use CAM when seeking greater control over their health in the face of dissatisfaction with Western medical approaches to health and wellness and/or concern about the risks associated with Western medical treatments (Bakx 1991; Caspi et al. 2004; Kennedy 2005; Pawluch et al. 2000; Siahpush 1998).

In addition, the findings presented in chapter 4 suggest that participants' expression of their desire for individual responsibility and control over their health varied depending on how they viewed Western medicine. Participants who grew dissatisfied following Western medical encounters and concerns about the safety and efficacy of Western medical treatment for their illness largely began using herbal medicine as an alternative to using Western medicine for that illness. Participants who believed that herbal medicine was more accessible and/or a better fit for their condition largely began using herbal medicine as a form of "proactive insurance" to prevent the need to use Western medicine (see Egan et al. 2011; Pagan and Pauly 2005). And most participants who utilized both herbal and Western medicine described how they established a boundary between their authority and their doctor's authority in determining the best course of treatment (both for themselves and their children).

The place of Western medicine

The findings of this research also indicate that participants' postmodern beliefs and values did not wholly stem from anti-science and anti-technological beliefs as proposed in both the postmodern thesis and the push-pull framework. As discussed in chapter 4, participants' distrust of science and technology manifest in their beliefs and attitudes with regard to Western medicine's dependence on modern scientific explanations of illness and health, the risks associated with Western medical treatments, and the profit motive underlying the medical and pharmaceutical industries. This finding suggests that participants' choice to use herbal medicine stemmed less from dissatisfaction with the science and technology used in Western medicine, and more from distrust in how science and technology were employed in the for-profit medical and pharmaceutical industries.

In summary, this research largely confirms the presence of beliefs, attitudes, and values associated with the postmodern thesis and push-pull framework advanced to understand why and how people use CAM. However, these models shed light on only parts of the paths traversed by participants in this research in the process of beginning to use herbal medicine. The postmodern thesis largely helps to shed light on the shared values and beliefs that led many participants to develop a general interest in herbal medicine. However, the postmodern thesis does not distinguish between the influence of these values in the decision to begin and the decision to continue using CAM, whereby the findings of this research suggest that some participants developed these values and beliefs throughout the course of continuing to use herbal medicine. And, while postmodern beliefs and values seem to have inspired some participants' interest in herbal medicine, the findings of this research indicate that participants' general interest in herbal medicine was not a particularly salient reason for why they began using herbal medicine. Instead, these participants indicated that their interest in herbal medicine led them to seek and be open to knowledge about its use during adulthood, which was cited as the most salient influence upon participant's choice to begin using herbal medicine second only to situational conditions concomitant with varying degrees of dissatisfaction and/or concern with Western medicine. The push factors identified in the push-pull model help to shed light on how dissatisfaction stemming from Western medical encounters can influence one to begin using herbal medicine. However, it does not account for many participants who developed an interest in herbal medicine but did not begin using it until a situational condition prompted its use. Further, the push-pull model seemingly belays participants' agency in the process of actively seeking knowledge about herbal medicine and making a pragmatic choice to use herbal medicine. The findings of this research also suggest that participants were not wholly anti-science or anti-technology; rather,

participants indicated concerns about how science and technology was used by the medical industry. Perhaps most importantly, while Andersen and Newman's 1973 (see also Andersen 1995) model of health care choice accounts for enabling factors, neither the postmodern thesis or the push-pull model account for how participants learned to use herbal medicine. Next I turn to a discussion of how participants indicated learning about herbal medicine.

Learning How to use Herbal Medicine

"Decision paths"

While the postmodern thesis and push-pull framework discussed above call attention to the influence of beliefs, attitudes, and values upon a person's motivation to use CAM, they do not account for the importance of learning how to use herbal medicine voiced by participants.

Previous work that sought to distinguish the sequencing of events that led people to start using CAM proposed a linear model whereby their participants either became dissatisfied with Western medicine, followed a recommendation to investigate CAM, and then researched CAM (i.e., Sharma 1990); or they had an interest in CAM, consulted with a CAM practitioner and deemed it a favorable experience, incorporated the practice of CAM, and then sought knowledge of its use (i.e., Semmes 1990, c.f. Siahpush 1999). Upon learning more about CAM, participants in both of these studies began regularly using CAM.

Sharma's (1990) findings most closely resemble the influence of push factors identified in the push-pull model, while Semmes' (1990, c.f. Siahpush 1999) findings most closely resemble the factors identified in the postmodern thesis and the pull factors identified in the push-pull model described above. Not unlike the partial explanations offered by the postmodern thesis and the push-pull model, these studies shed light on parts of the paths that some participants in this

research tread in the process of beginning to use herbal medicine. Sharma's (1990) sequence most closely approximates the path that participants took when their interest in herbal medicine stemmed primarily from emergent dissatisfaction with the Western medical approach to their ailments, and Semmes' (1990, c.f. Siahpush 1999) findings would approximate the path that participants who began using herbal medicine primarily out of an interest in its use if the consultation with a CAM provider and resulting satisfaction with that experience were omitted. Yet, echoing the limited applicability of the push-pull framework to the findings of this research, neither of these sequence studies captures the plight of participants who had an interest in herbal medicine and then pursued its use after prompted by a situational circumstance during which herbal medicine was believed to be safer, more effective, more accessible, or a better fit than Western medicine.

The findings of this research largely indicate that an interest in herbal medicine, whether arising from related beliefs and values or from dissatisfaction with Western medicine, often arose in tandem with seeking knowledge about its use. In this way, participants generally experienced the influence of an interest in herbal medicine and learning about herbal medicine in a dialectical, rather than linear, fashion. Further, the findings of this research shed light on how participants varied in types of knowledge they acquired as well as the ways that they acquired knowledge, or how they took different "decision paths," depending on their intention for using herbal medicine (Bishop et al. 2007; Caspi et al. 2001).

Participants whose path into using herbal medicine began with an interest in its use largely sought broad information about its use from texts and work experiences and were open to information offered by peers and CAM practitioners encountered throughout the life course. On the other hand, participants who began using herbal medicine to treat chronic illness were more

likely to research texts for information about the specific use of herbal medicine for their condition and to be open to recommendations from others encountered during the illness process.

The knowledge that some participants acquired from people they encountered during their illness experience was, in some cases, an example of what Bell (2004) termed ‘dialogic providence,’ characterized as a sort of situational luck whereby during a period of crisis, such as a health crisis, one is open to new knowledge cultivations, “cultivations whose words just happen at that very moment to come drifting your way...” (pp. 162-63). This phenomenon is best described by Jeanette when a conference participant recommended the use of food grade hydrogen peroxide to treat her lymphoma:

I just had this diagnosis with lymphoma and I happened to be at a conference and met a reporter and he just happened to be doing an article on oxygen therapies, and he’s like, look, you should really look into this. And he was kind enough to actually meet up with me later, and he gave me a lot of his reference material. ... This sounds like this thing fell out of the heavens as far as I’m concerned, potentially meeting this reporter and him just happening to be doing research on this article.

Whereas participants who were drawn to herbal medicine by way of experiences and social influences throughout their life course described their affinity for reading and learning (see chapter 3), participants who sought information on the use of herbal medicine to treat a specific health condition referred more so to their research skills (see chapter 4). For example, Theresa described herself as a “natural researcher,” Morgan and Steven as being “good at research” and a “good researcher,” and Mary as a “library buff.” This difference reveals how participants draw upon different personal skills and aptitudes with regard to finding information on the use of herbal medicine depending on whether they first sought knowledge on the use of herbal medicine primarily out of a general interest in herbal medicine use or to treat a specific condition.

Acquiring knowledge

The findings of this research confirm previous survey research finding that people largely learn about herbal medicine from family and friends, followed by texts, and a small percentage of people who learn from CAM providers and health food store employees (Ambrose and Samuels 2004; Craft et al. 2015; Kuo et al. 2004; Lohse et al. 2006; Perkin et al. 2002). As discussed in chapters 3 and 4, the findings of this research add qualitative depth to understanding how participants sought or were offered information about herbal medicine from family, friends, texts, CAM practitioners, and health food stores. For instance, participants developed an awareness of and varying degrees of experiential knowledge about the use of herbal medicine from their parent's use of herbal medicine growing up, where some of these participants also developed a respect for herbal medicine upon resuscitating the history of their family's traditional practice of herbalism.

While Goldstein (2002) hypothesizes the influence of increased CAM advertising upon people's use of CAM and Craft et al. (2015) identified advertising as a source of herbal information by over 10% of their survey respondents, no participants indicated the influence of advertising upon their choice to begin using herbal medicine. This finding likely reflects the motivations underlying the choice to use herbal medicine espoused by participants in this research. On one hand, some participants sought information on herbal medicine out of a general interest in its use to maintain their health. On the other hand, some participants sought information about the use of herbal medicine to treat a specific condition. Therefore, herbal product advertising would have likely not resonated with these participants.

Further, previous survey research found that people learned about herbal medicine from their primarily care doctor, pharmacist, or coach or athletic trainer (Ambrose and Samuels 2004; Craft et al. 2015; Kuo et al. 2004; Lohse et al. 2006). However, these information sources were not identified by participants in this research as influential in their choice to begin using herbal medicine. In addition, previous research indicates that a positive experience with a CAM practitioner influences people to begin regularly using that CAM therapy (Broom and Adams 2009; Semmes 1990, c.f. Siahpush 1999; Sirois and Gick 2002; Sointu 2006). However, participants did not indicate the influence of consulting with an herbalist on their choice to use herbal medicine. Instead, participants indicated learning about herbal medicine through consultation with other CAM practitioners and indirectly by reading texts authored by herbalists. Participants indicated that their experiences working with herbal medicine on farms where herbal medicine was grown and processed and in health food and herb stores where herbal medicine was sold were very important in acquiring experiential knowledge about the practice of herbalism that led to their use. Participants also indicated that reading texts and conversing with peers about information learned from texts and work experiences were very important influences upon their choice to begin using herbal medicine. The extent to which first-hand experiences with a particular CAM therapy influences a person's choice to use that CAM therapy is not, insofar as I can detect, discussed in previous literature.

Next I turn to a discussion of the distinctiveness of herbal medicine compared to many other CAM therapies, which entails a review of the contributions of this research to the larger body of existent research seeking to understand why people use CAM and a discussion of the importance of learning how to use herbal medicine in the process of making the choice to use herbal medicine.

The Distinctiveness of Herbal Medicine

The findings of this research compared to previous research on other specific CAM therapies or CAM in general signal a number of distinctions between herbal medicine compared to other CAM therapies, as well as between influences upon a person's choice to begin using herbal medicine and influences upon the choice to continue using herbal medicine. In this section, I detail key differences observed with regard to the practice of herbal medicine unveiled in this research compared to research on other CAM therapies so as to better understand why the findings of this research failed to confirm or support some findings indicated in the larger body of CAM use and generated findings that are not well documented in previous research. I surmise that the observed differences of herbalism compared to other CAM therapies stem from the widespread historical and traditional practice of herbal medicine in America, the root of modern pharmaceutical medicine in medicinal plants, the empirically observable pharmacological actions of medicinal plant compounds, laws and regulations governing the practice of herbalism, and the do-it-yourself approach to practicing herbal medicine.

Of all extant complementary and alternative medical approaches in America, I can detect none that are more rooted in the American practice of medicine than herbalism. Plants were the primary form of medicine in colonial America, practiced predominately by Native Americans, midwives, and women until the 18-19th centuries when professional medical sects emerged and competed for medical dominance (Griggs 1997; Starr 1982). While the traditional practice of herbal medicine was largely suppressed and discredited (Reifel 1999; Tilly 1999; Wertz and Wertz 2012), the eclectic sect retained the practice herbal medicine. The competition for medical dominance in America largely ended in the early 20th century as the allopathic medicine sect gained political support and instituted physician licensing boards that, for the most part,

excluded medicinal plant practitioners (Haller 1994; Ruggie 2005). In this way, allopathic medicine erected boundaries to monopolize the professional practice of medicine in America by way of excluding its rivals from legally practicing medicine (Gieryn 1983). The dominance of allopathic medicine throughout the 19th and 20th centuries ushered a transition from whole plant medicine to patent medicine, characterized by the isolation, synthetization, and concentration of plant compounds into tablet form. Modern pharmaceutical medicine is primarily composed of synthetic compounds whereby 1/4-1/3 of pharmaceutical medicine is derived to some degree and in some form from plants (Bent and Ko 2004).

Despite the historical suppression of herbal medicine in America, the finding that some participants developed a respect for herbal medicine that stemmed from unearthing the traditional practice of herbal medicine in America suggests that these American roots in the practice of herbalism still influence present-day herbal medicine users. Further, some participants indicated a respect for the traditional use of herbal medicine unrelated to their ancestry and paid homage to the herbalists who left a legacy of textually-based knowledge for them to draw from. And a few participants invoked to their awareness of the historical suppression of herbal medicine in America as a seemingly political motivation to actively seek and reproduce historical accounts of medicinal plant effects. For instance, following an account of the historical suppression of herbal medicine knowledge, Morgan described how “we are in a process of having to keep this knowledge alive by whatever means we can and keep it in practice against many forces that would like to see us go away.”

The finding that all but one participant indicated concerns with pharmaceutical medicine that influenced their use of herbal medicine suggests that participants actively sought herbal medicine in an effort to avoid pharmaceutical medicine. Herbal medicine users’ concerns about the side

effects of pharmaceutical medicine in concert with beliefs about the relative safety of herbal medicine to pharmaceutical medicine are documented in previous research (Holst et al. 2009; Mitchell and McClean 2014; Pole et al. 2000; Vickers, Jolly and Greenfield 2006; Westfall 2003). It may be that these concerns are more widespread and more influential among herbal medicine users because herbal medicine is, perhaps alongside homeopathy, the most similar to pharmaceutical medicine insofar as someone chooses to consume or apply a pharmacologically active substance for a desired effect upon the body or mind.

This political motivation to use herbal medicine is not, insofar as I can detect, evidenced in previous research. This indicates that the political motivation uncovered in this research may be distinct to the use of herbal medicine, and perhaps other CAM modalities that were likewise historically marginalized and suppressed by professional, economic, and political forces (e.g., homeopathy, chiropractic). Accordingly, the political motivation for using herbal medicine espoused by some participants may not be indicated in previous research that examined CAM in general or other CAM therapies. Yet, my review of previous research, while limited by its relevance to the scope of this research project, did not detect a political motivation among chiropractic users.

While there are a host of factors that need be controlled for in order to scientifically demonstrate that a specific plant compound has a pharmacological action on the body (e.g., natural variations in the potency of plant compounds and medicinal effects on biologically unique individual bodies), there is a growing body of scientific research that seeks to understand the science underlying the medicinal actions of plants. According to the Institute of Medicine (US) Committee on the Use of Complementary and Alternative Medicine by the American Public

(2005), herbal medicine and dietary supplements are the most scientifically reviewed CAM therapies.

However, difficulties in demonstrating the efficacy of medicinal plants in evidence-based medicine persist as standardizing biologically unique plants and human bodies and quantifying subjective indicators of efficacy is difficult at best (Adams et al. 2002; Barry 2006; Evans 2008; Hollenberg and Muzzin 2010; Jagtenberg et al. 2006). As surmised by Derkatch (2008) and other critics, evidence-based medicine is largely unable to measure the efficacy of herbal medicine as practiced in the everyday lives of its users. Modern day Western herbalism is thought to be bifurcated into two camps: the practice of traditional herbalism in line with traditional notions of safety and efficacy, and the practice of scientific herbalism in line with scientific notions of safety and efficacy (Evans 2008; Singer and Fisher 2007).

While I observed and recorded this bifurcation of herbalism in the way that participants practiced herbal medicine, participants generally fell along a spectrum from traditional to scientific practices whereby the majority of participants incorporated elements of both in their daily practice of herbal medicine. Many participants indicated varying degrees of the desire for more reliable information to guide their personal use of herbal medicine and, in some cases, to inform the Western medical community in the movement towards integrative medicine. When it came to the desire for more scientific research on the efficacy on herbal medicine, some participants indicated obstacles in generating reliable scientific research stemming from a holistic understanding of the difficulty of evidence based research to scientifically evaluate the efficacy of medicinal plants, a lack of funding, and conflicts of interest in funding. The diversity of participants' views regarding the state of and desire for scientific knowledge on the use of herbal medicine reflects conflicts detailed by Welsh et al. (2004) among CAM practitioners in Canada

in their pursuit of state sanctioned self-regulation, including the extent to which CAM education, practice, and research should incorporate elements of allopathic education, practice, and research.

Participants' desire for more scientific research on herbal medicine provides evidence that many herbal medicine users in this study are not anti-technology or anti-science, which in turn suggests that this characterization of CAM users may be more prevalent among users who utilize CAM therapies that have less scientific backing, such as mind-body CAM therapies. Instead of voicing dissatisfaction with scientific research, participants largely pointed to the obstacles in generating scientific research on herbal medicine posed by evidence based research and the influence of the health care and pharmaceutical industries.

While one might expect that indications for how to use herbal products for specific effects would be indicated on the product's packaging, US FDA regulations specifically prohibit herbal product manufacturers from claiming that an herbal product can "diagnose, treat, cure, or prevent any disease." Further, if product manufacturers make any indication that the herbal product has any effect on the body, they must include a disclaimer on their product labels.⁴ In addition, there are no US state licensing boards to legally certify herbalists' practice of medicine (American Herbalists Guild 2014). Thus, herbal practitioners cannot legally practice medicine, such as by communicating in any way that might be construed as indicating that they can diagnose, prescribe, or treat or cure disease. In response, herbalists often impart information of how to use herbal medicine in informal and educational settings, such as on herb walks, in classes, and by authoring texts. The American Herbalist Guild is the largest professional association for herbal

⁴ I.e., According to the 1994 Dietary Supplement Health and Education Act, all indications of herb effects must also include the following: "This statement has not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevents any disease."

practitioners in America and the only professional organization that confers the title of a “Registered Herbalist” pending approval of a detailed membership application.

Some participants indicated obstacles to learning about and practicing herbal medicine with reference to the belief that information about the use of herbal medicine is actively suppressed by way of FDA regulations and medical licensing laws. In these cases, participants pointed to the influence of pharmaceutical industry upon political institutions to maintain their dominance in the practice of medicine, and thus upon the profits gained by widespread pharmaceutical use, at the expense of limiting the expression of professional knowledge about how to use herbal medicine. In addition, participants’ lack of reference to first learning about herbal medicine by way of consulting with an herbalist or reading herbal product labels was likely, in part, a result of these obstacles that are specific to laws governing the practice of herbal medicine in America.

Lastly, the practice of herbal medicine is distinct from some other CAM therapies because it is largely a do-it-yourself CAM modality (as opposed to practitioner-provided therapies such as chiropractic, Reiki, and massage). As explained by Peeka Trenkel in Dougherty’s (2004) interviews with herbalists, “herbal medicine is like cooking. You can go to school to become a chef or you can make bean soup at home and bake your own bread. You are still using food, and you are still doing nourishing things.” That is to say that using herbal medicine is not unlike preparing other edible plants for consumption, something that the vast majority of people are capable of learning and doing without consultation with an herbal provider.

The do-it-yourself quality of herbal medicine may explain why previous research has not identified the personal practice of a CAM therapy as an influence upon a person’s choice to use that CAM therapy. This is likely because experiencing most CAM modalities constitutes a

choice to use that CAM modality. For example, interactions with CAM practitioners factor predominately in existing research that sought to understand the process by which people turned to chiropractic care (e.g., see Semmes 1990, c.f. Siahpush 1999; Yardley et al. 2001) and CAM therapies in general (e.g., see Hok et al. 2007; Sointu 2006). Rather than receiving professional guidance or regular herbal treatments from a provider, participants indicated that they integrated the practice of herbal medicine into the structure of their everyday lives—they were the provider and the patient. According, learning how to use herbal medicine was indicated by many participants as a very important part in the process of first using herbal medicine.

Making the Choice to Continue Using Herbal Medicine

This research sampled from a population of current herbal medicine users; accordingly, all participants continued their use of herbal medicine after making the choice to use herbal medicine and deeming it effective for its intended purpose. In some cases, participants experienced a phenomenological rupture whereby health crises drove them to rethink how they could heal themselves from chronic illness outside of the realm of Western medicine (see Bell 2004). Participants had to rethink not only how to go about treating their condition, but also how to change their lifestyle and diet to accommodate and effectively use herbal medicine. The phenomenological rupture lies in participants' accumulation of embodied knowledge that functioned as a renewed impetus to continue using herbal medicine.

The findings of this research demonstrate that most participants drew upon a set of hybrid knowledge (Keshet 2010), a collection of different ways of knowing how to use herbal medicine and knowing if herbal medicine would be effective derived from epistemologies underlying both Western medicine and herbal medicine, to inform their use of herbal medicine to treat emergent

health conditions. Upon experiencing a health need, most participants indicated that they observed their health status and first considered herbal medicine and other natural therapies. After evaluating the perceived efficacy and fit of different treatments available to them, participants made a pragmatic choice about which approach(es) to pursue (see Conrad 2012; Gale 2014; MacArtney and Wahlberg 2014). In other words, they became what Broom (2009) termed bricoleurs, selecting the best medical therapy available from a wide array of treatment options to find relief from their particular condition.

In addition to the knowledge sources discussed above, participants indicated that they largely relied upon embodied knowledge of how particular herbal medicines affected their particular bodies in order to direct how they continued using herbal medicine. Participants reported listening to their body and working with herbal medicine to learn how to use particular medicinal plants in particular ways for specific health outcomes with reference to their individually unique and constantly evolving physical, mental, and spiritual states, a behavior termed by Gale (2011) as body work, to find that herbal medicine was effective. Accordingly, participants in this research may be termed embodied activists, characterized as lay activists who are empowered to take responsibility for their health by way of self-monitoring and self-care in resistance to Western medical control of the body (Broom et al. 2010; Fries 2003; Gale 2014).

Participants' cultivation of knowledge of how to use herbal medicine from texts and talk alongside experiential knowledge gained from observing the use of herbal medicine to treat emergent conditions informed their personal use of herbal medicine. In result, they cultivated a new body of embodied knowledge whereby they learned more about how to use herbal medicine to treat their particular illness as they experienced it that increased their interest in learning more about its use. That is to say, the dialectic between an interest in herbal medicine and learning

about herbal medicine use engaged in a dialectical relationship with conditions prompting herbal medicine use and finding it effective to use for that condition. This constituted the process of regularly using herbal medicine, a process that was additionally fueled by the growth of attitudes and beliefs about Western medicine compared to herbal medicine. This finding supports the small body of existing research that identified the influence of the dialectic between patients' abstract beliefs about the etiology and treatment of their ailments and their treatment experiences; and the influence of a high degree of health awareness, dissatisfaction with Western medicine, the perception of a good fit between the CAM therapy and health condition, and the perception of CAM's efficacy (Sirois and Gick 2002; Sirois, Salamonsen, and Kristoffersen 2016; Yardley et al. 2001).

Participants indicated varying degrees of concern, as well as support, and even praise, for the ability of Western medical science and technology to evaluate their health by way of diagnostic and preventative care, to treat sudden illness and traumatic injuries, and to relieve chronic and/or severe pain. That is, participants believed that there is a place for Western medicine in the plurality of medical therapies available to them. This finding supports previous research indicating that despite varying levels of dissatisfaction with Western medicine, most CAM users do not completely reject Western medicine (Khokher 2009; Pawluch et al. 2000; Sharma 1990; Vincent and Furnham 1996).

Accordingly, I find it difficult to characterize the use of herbal medicine among most participants represented in this research as either a complement or alternative to Western medicine. Instead of coming from a Western medicine mindset, whereby they might consult with a doctor at the first sign of illness, participants overwhelmingly indicated that they came from a natural medicine mindset. In this way, I surmise that most, if not all, participants used Western

medicine as a complement to herbal medicine when herbal medicine and other CAM therapies were deemed ineffective or not the best fit to treat their condition.

Some of the findings discussed in this chapter that diverge from findings in previous work also stem from the focus of this research on understanding how the process by which people make the choice to begin using herbal medicine, rather than how people chose to continue using herbal medicine. For instance, participants indicated learning more about the use of herbal medicine through consultations and classes with herbalists as they continued to use herbal medicine throughout the years. And, a few participants indicated learning more about herbal medicine from advertising, such as on television talk shows and in magazines.

The relationship between participants' interest in herbal medicine and in other CAM therapies often evolved throughout the use of them. That is, all participants indicated the use of other CAM therapies in tandem with their continued use of herbal medicine, including chiropractic, massage therapy, homeopathy, acupuncture and acupressure, iridology, meditation, craniosacral therapy, naturopathy, other forms of body work (including yoga, Pilates, and Alexander technique), energy work (including Reiki), aromatherapy (including the raindrop technique⁵), and/or the use of other dietary supplements. As participants continued to use herbal medicine, their interest in natural health and CAM therapies continued to grow and encompass additional complementary and alternative means of sustaining their health and treating emergent health needs (a finding also noted by Sharma 1990).

Throughout the course of using herbal medicine, most participants also indicated an emergent affinity for and/or participation in other social movements, including movements relating to

⁵ According to the Center for Aromatherapy Research and Education (2016), the raindrop technique is practiced by a practitioner dropping selected essential oils onto the back and then massaging the oil into the skin.

health and wellness (e.g., health collectives and reduced-fee CAM clinics, professional herbalism, anti-vaccination), food and agriculture (anti-genetically modified foods, local foods, organic foods, raw foods, farmer's markets, vegetarianism and veganism, farmer's legal defense), environment (Sierra Club, Environmental Defense Fund), social justice (Human Rights Campaign, Occupy, Food Not Bombs, women's rights), and more (including Chemtrails and political campaigns). Thus, not unlike participants' growing interest in CAM therapies, an affinity for social movements also grew as a reinforcing influence throughout participants' continued use of herbal medicine.

LIMITATIONS

This research represents accounts of herbal medicine use from 28 current, regular herbal medicine users in Cincinnati, Ohio and St. Louis, Missouri. Thus, the findings of this research are not generalizable beyond their application to these participants. This research did not sample from the population of people who may have tried herbal medicine but discontinued its use or people who may have only sporadically use herbal medicine. Recruitment for this research primarily took place by way posted flyers, herbalist recruitment, and word of mouth; and were limited to Cincinnati, Ohio and St. Louis, Missouri city limits. While word of this research did reach participants who resided outside of both cities' limits, this research is skewed towards people who lived in or frequented locations where I advertised this research. Thus, this research may not reflect sub-cultures of herbal medicine users who do not frequent areas or avenues that I advertised this research through, such as in rural areas where people may rely upon locally or self-grown herbal medicine and neighboring Native American communities. Further, these research findings cannot be generalized to other cities, regions, or countries because the quality and quantity of accessible herbal medicine knowledge, product availability, availability and

accessibility of professional practicing herbalists, health insurance coverage of CAM, and influential sub-cultures and movements are likely to vary by locale.

It is additionally unknown what participants' motivations were for interviewing with me or the degree to which their motivations affected what they chose to share with me during interviews. As described in chapter 2, some of the people I talked to about this research voiced suspicion and distrust with regard to the motivations underlying this research and how the findings of this research would be used that presented some barriers during the recruitment and interviewing phases of this research. Thus, this research may not include the perspective of herbal medicine users who were interested in this research but may not have participated out of concerns of how their words would be used. While participants were generally forthcoming with information and experiences during interviews, it is possible that participants withheld information that they perceived could be used in a way that was counter to their interests (e.g., such as for herbal product advertising or to frame medicinal plant users in a negative fashion).

My status as a convert (i.e., an herbal medicine user) was implicitly disclosed to participants in my introduction to them about my previous work and interest in this field of research. This in turn may have also influenced what participants shared, and did not share, with me during interviews. Further, my status as a convert may have unintentionally influenced the way in which I interacted with participants, interpreted their words, and analyzed and reported the findings of this research. For instance, in order to comply with my reassurances that I did not intend to frame this research in a way that discredited participants' experiences with herbal medicine, and in line with my primary aim in understanding how people begin using herbal medicine rather than in critiquing participants' experiences and knowledge claims, I have knowingly avoided explicit scientific critiques regarding some of the ways that participants

indicated learning about herbal medicine (such as through “instinct”) and beliefs about illness and Western medicine that may reflect misinformation. As such, my focus on the authenticity of participants’ accounts over the validity of their accounts, in part due to the interpretive approach driving this research and my status as an herbal medicine user who shares many of the beliefs and attitudes espoused by participants, reflects another limitation of this research.

Limitations also stem from the research methods employed. Interviews were guided by open-ended questions in a semi-structured interview guide so as to allow participants to freely self-identify the myriad influences they experienced upon their choice to begin using herbal medicine. Thus, it is possible that participants would have indicated more influences if probed for them specifically. For instance, all participants may have been influenced by childhood experiences with nature or Western medicine, but did not think of these influences during the time of the interview.

DIRECTIONS FOR FUTURE RESEARCH

Future work exploring why and how people begin and then discontinue herbal medicine use, such as by a comparative analysis of current and former herbal medicine users, can contribute an understanding of why and how these populations began using herbal medicine, why they discontinued their use of herbal medicine, and shed light on how these influences may vary between these groups. Reproducing this research among other populations of herbal medicine users, such as in different geographical locations, different ethnic and racial groups, different age groups, and different economic classes, may reveal different influences, experiences, and obstacles to using herbal medicine, such as the differential impact of sub-cultures and social movements that are bound to a particular location or time period, the influence of different herbal

traditions, different health need indications for use, and different herbal use practices relating to the costs of both Western and herbal medicine.

A comparative analysis of how different CAM therapy users (e.g., such as herbal medicine and acupuncture users) use that CAM modality for the same health need or purpose (such as to treat cancer, during pregnancy) can shed light on how one chooses to use a CAM therapy over another for different symptoms. And, replicating this research among a much larger population of CAM users may also reveal correlations among different health needs, beliefs and attitudes about Western medicine, and the use of specific CAM therapies. Further, investigating whether and to what degree people develop and invoke beliefs and attitudes about pharmaceutical medicine and beliefs and values associated with the postmodern thesis prior to their choice to begin using and while continuing to use herbal medicine can shed light on whether and to what degree these influence people's choice to start and to continue using herbal medicine and other CAM therapies. Directly inquiring about political motivations for using herbal medicine, homeopathy, and chiropractic may shed light on whether and to what degree the historical suppression of these CAM therapies influence people's use of them.

Utilizing different research methods to understand how people use herbal medicine, such as participant observation over a longer period of time and asking participants to complete journals on their use of herbal medicine, may cultivate a greater sense of trust in and control over the research process among participants and generate more comprehensive, in-depth, and representative accounts. Further, utilizing journals or otherwise soliciting written responses to questions that some participants had difficulty recounting answers to, such as recounting the different herbs that participants used, the myriad ways they used herbal medicine in everyday life, and the text resources that inform their use, may also generate a more comprehensive and

richer set of data with regard to how people use herbal medicine and the information sources they draw from.

Interview-based research on why and how people use CAM can incorporate follow-up interviews in an effort to more exhaustively identify and discuss all the factors that influence people to use CAM, which in turn may illuminate further complexity in making the choice to use CAM.

Incorporating follow-up interviews may also allow for more in-depth probing consistent with emergent themes so that data are collected in line with grounded theory methodology and thus contribute a fuller understanding of influences and experiences that the single interviews in this research signaled but were ill-equipped to explore further. For instance, this research unveiled some findings that were not solicited or systematically explored, including the costs associated with the daily practice of herbal medicine, views on genetically modified foods, different epistemologies underlying participants' practice of herbalism, and participants' use of herbal medicine on their children and family pets. A systematic exploration of these emergent themes that are not systematically analyzed in previous research will contribute an understanding of their role in herbal medicine use.

Future work can also address the "big question" of how people know that herbal medicine is effective (see Gale 2014), such as by inquiring about specific criteria that people use to measure the efficacy of herbal medicine and soliciting detailed accounts of instances where people believed herbal medicine worked. Soliciting information from herbal medicine users that is specifically suited to guide policies on the use of herbal medicine in America, such as by inquiring about herbal medicine users' stance in the debate over licensure of herbalists, attitudes regarding insurance coverage of CAM following the passage of the 2010 Affordable Care Act, and FDA laws on labeling and quality control of herbal products, could uncover information that

can better direct the future of the practice of herbalism and integrative medicine in America. Lastly, soliciting herbal medicine and CAM users' and practitioners' thoughts with regard to their preference for, concerns about, and idealized visions of integrative medicine can generate recommendations to guide Western medical practitioners who wish to become more integrative in their approach to health and illness as well as policy makers who regulate the practice of CAM and Western medicine.

CONCLUSION

In conclusion, this research contributes a qualitative understanding of how 28 current, regular herbal medicine users first began using herbal medicine to the small body of research in the Sociology of CAM that seeks to understand why and how people are increasingly using CAM therapies. The findings discussed in this work indicate that the process of making the choice to use herbal medicine often begins with an interest in herbal medicine cultivated by social and cultural influences and experiences accumulated throughout the life course, and sometimes by experiencing a health need and concomitant beliefs and attitudes about Western medicine. Many participants indicated that their interest in herbal medicine evolved in a dialectical relationship with learning about herbal medicine, whereby both grew in their influence upon the other and on participants' choice to begin using herbal medicine.

The findings of this research indicate that participants generally tread one of three paths in the process of making the choice to use herbal medicine: Some participants began using herbal medicine primarily out of an interest in and knowledge about its use, sometimes in concert with concerns about pharmaceutical medicine; while other participants who were armed with an interest in and knowledge about herbal medicine did not begin using herbal medicine until they

encountered a situation that prompted its use in tandem with the belief that herbal medicine was safer, more effective, more accessible, or a better fit to treat the condition. On the other hand, some participants did not develop an interest in or knowledge about the use of herbal medicine until they experienced a health need in tandem with some degree of dissatisfaction with Western medicine or the belief that herbal medicine was more accessible than Western medicine.

Participants who experienced situational conditions alongside a preference for herbal medicine over Western medicine indicated that their experience being ill, injured, pregnancy, and/or without health insurance, oftentimes alongside dissatisfaction with Western medicine, were the most salient influences upon their choice to use herbal medicine. Most participants indicated that learning about herbal medicine was more influential on their choice to start using herbal medicine than their interest in herbal medicine. All participants indicated that while they preferred to use herbal medicine, they believed that Western medicine was a better fit for some conditions and that they would seek Western medical assistance if they believed their condition warranted its use.

The findings of this research uncovered varying degrees of overlap with and support of previous research findings with regard to why people use CAM. The focus of this research on understanding the process of making the choice to use herbal medicine, including the sequence and relative importance of influences upon participants' choice to use herbal medicine, adds qualitative depth to existing research findings. Yet, the findings of this research also did not support some findings indicated in previous research; and the findings of this research identified factors contributing to participants' use of herbal medicine that were previously not indicated or well documented in previous research. I surmise that these areas of overlap and divergence reflect the primary focus of this research upon understanding how people make the choice to

begin (rather than continue) to use herbal medicine (as opposed to other CAM therapies). The findings of this research support the utility of distinguishing between different CAM therapies when ascertaining why people use CAM (Bishop et al. 2006, 2007; Kelner and Wellman 1997; Vincent and Furnham 1996); as well as distinguishing between influences upon the choice to begin and the choices to continue using CAM (Baarts and Pederson 2009; Bishop et al. 2006, 2010; Sharma 1990; Siahpush 1999; Sirois and Gick 2002; Sirois, Salamonsen, and Kristoffersen 2016). Lastly, the findings of this research generated a number of ideas for additional research to further academic understanding of why and how people are increasingly using herbal medicine and other CAM therapies.

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Appendix A: Human Subjects Approval



11/27/2012
HSCL #20537

Rachel Craft

The Human Subjects Committee Lawrence Campus (HSCL) has received your response to its expedited review of your research project

20537 Craft/Smith (SOCIOLOGY) The Social Production of Medicinal Plant Knowledge

and approved this project under the expedited procedure provided in 45 CFR 46.110 (f) (7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. As described, the project complies with all the requirements and policies established by the University for protection of human subjects in research. Unless renewed, approval lapses one year after approval date.

The Office for Human Research Protections requires that your consent form must include the note of HSCL approval and expiration date, which has been entered on the consent form(s) sent back to you with this approval.

1. At designated intervals until the project is completed, a Project Status Report must be returned to the HSCL office.
2. Any significant change in the experimental procedure as described should be reviewed by this Committee prior to altering the project.
3. Notify HSCL about any new investigators not named in original application. Note that new investigators must take the online tutorial at http://www.rcr.ku.edu/hsc/hsp_tutorial/000.shtml.
4. Any injury to a subject because of the research procedure must be reported to the Committee immediately.
5. When signed consent documents are required, the primary investigator must retain the signed consent documents for at least three years past completion of the research activity. If you use a signed consent form, provide a copy of the consent form to subjects at the time of consent.
6. If this is a funded project, keep a copy of this approval letter with your proposal/grant file.

Please inform HSCL when this project is terminated. You must also provide HSCL with an annual status report to maintain HSCL approval. Unless renewed, approval lapses one year after approval date. If your project receives funding which requests an annual update approval, you must request this from HSCL one month prior to the annual update. Thanks for your cooperation. If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads 'Christopher Griffith'.

Christopher Griffith, J.D.
Assistant Coordinator
Human Subjects Committee- Lawrence

cc: David Smith

Appendix B: Informed Signed Consent Form

Approved by the Human Subjects Committee University of
Kansas, Lawrence Campus (HSCL). Approval expires one
year from 11/27/2012 HSCL # 20537

Informed Signed Consent Statement for Interview and Participant Observation

The Department of Sociology at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw from this study and/or to refuse to answer any questions at any time without penalty.

We are conducting this study to better understand why and how people use medicinal plants and herbal products. This interview should take no more than 1-2 hours of your time and will consist of several questions regarding your use of medicinal plants, including your history and current status of medicinal plant and herbal product use and how you learn to prepare, administer, and use medicinal plants safely and effectively.

With your permission, I will audio-record this interview, upload the recording to my personal, secure, and password-protected computer, and transcribe this interview. Also, with your permission, I would like to take pictures of your herbal use, including photographs of your plant collection, preparation, administration, and sources of knowledge. The audio recording and photographs are not a necessary component of this interview. You may choose not to consent to audio recording and/or photographs, and you may ask that audio recording be stopped and/or that the investigator stop taking pictures at any point during the interview without penalty. All data collected, including audio recordings, interview transcripts and notes, and photographs will be destroyed in five years.

Your participation in this interview should cause no more discomfort than you would experience in your everyday life. Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of why people use medicinal plants and how they learn to use medicinal plants in a safe and effective way. Such information can inform policies regarding medicinal plant and herbal product use in the U.S. Your participation is solicited, although strictly voluntary.

Any identifiable information collected during the course of this interview will not be shared unless (a) it is required by law or university policy, or (b) you give written permission. All identifying information, if provided or collected during the course of this study, will be destroyed; or, in the event that you consent to follow-up communication with the primary investigator, will be stored separately from all other data and destroyed within one year of data collection. Your name will not be associated in any publication or presentation with the information collected about you or with the research findings from the study. Instead, the primary investigator will use a pseudonym or number rather than your name.

KU Lawrence IRB # 20537 | Approval Period 12/22/2014 – 11/27/2015

If you have any additional questions about this research study, or would like additional information concerning this study before or after it is completed, please feel free to contact the primary investigator, Rachel Craft, by email to rachelcr@ku.edu or by phone call to 314-971-8995.

If you have any additional questions about your rights as a research participant, you may call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email irb@ku.edu.

By signing this Consent and Authorization form, you affirm the following:

I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or (785) 864-7385, write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7568, or email irb@ku.edu.

I agree to take part in this interview as a research participant. By my signature I affirm that I am at least 18 years old and that I have received a copy of this Consent and Authorization form.

Type/Print Participant's Name	Date
-------------------------------	------

Participant's Signature

I DO grant permission to the investigator to audio record the interview.

I DO NOT grant permission to the investigator to audio record the interview.

I DO grant permission to the investigator to take pictures of my herbal use, including photographs of my plant collection, preparation, administration, and sources of knowledge.

I DO NOT grant permission to the investigator to take pictures of my herbal use, including photographs of my plant collection, preparation, administration, and sources of knowledge.

Rachel Craft
Primary Investigator
Department of Sociology
733 Fraser Hall
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KU Lawrence IRB # 20537 | Approval Period 12/22/2014 – 11/27/2015

Appendix C: Authorization for Release of Photographs

Authorization for Release of Photograph, Video, or Written Testimonials

I, _____ (*Name of Individual*), by signing this release, authorize the University of Kansas, the Department of Sociology, and their staff to use photographs, video images, or other likenesses of myself and/or my child, and the attached written testimonials, for the following purposes:

1. Use in University and Department of Sociology education and training activities and materials (including print and on line or electronic instructional materials); and
2. Use in print or electronic form in University or Department of Sociology publications, presentations, brochures, newsletters/bulletins, and websites for educational, public relations or promotional purposes which may result in the raising of funds for the Department of Sociology.

I understand that the images and written testimonials described above may be included in, copied and distributed by means of various print or electronic media. I understand that my and my child's name will not be included with the images or testimonials.

I understand that this Authorization can be revoked at any time to the extent that the use or disclosure has not already occurred prior to my request for revocation. In order to revoke the authorization, I must notify Department of Sociology in writing at the following address:

University of Kansas
Department of Sociology
Fraser Hall
Lawrence, KS 66045
785-864-4111
socdept@ku.edu

If I cancel this Authorization after publication of the materials outlined above, I understand that my cancellation may not be able to be honored. If I revoke this Authorization, the University and the Department of Sociology shall not engage in any new uses or disclosures of the images or testimonials.

The University and the Department of Sociology will not condition treatment, payment, enrollment or eligibility for services or benefits on the execution of this Authorization. I understand that the images and testimonials may be subject to re-disclosure by the person or entity receiving such information and thus will no longer be protected by federal privacy regulations.

This Authorization is given without promise of compensation. The photos, video images or other likenesses and the attached testimonials specified above become the property of the University of Kansas and I release to the University any right, title and/or interest of any kind that I and/or my child may have in the information or images produced.

I have read this document and understand its contents.

Signature of individual (or parent or guardian) _____

Relationship to individual _____

Date _____

The authorization must be signed and dated and a copy provided to the individual completing the form.

Appendix D: Recruitment Flyer

DO YOU USE HERBS OR HERBAL SUPPLEMENTS? WANT TO SHARE YOUR EXPERIENCE?

Research volunteers are needed for an herbal use study.

The purpose of this research is to find out who uses herbs and herbal supplements; why people use plants for medicine; and how people learn to use plants medicinally.

I am looking for volunteers who:

- are 18 years of age or older;
- used herbs or herbal supplements for health or well-being in the past year; and
- have 1-2 hours available for an interview.

All identifying information collected will be kept confidential.

There is no more risk in participating in this research than you experience in everyday life.

To participate in this research or for more information, please contact:

Rachel Craft

University of Kansas, Department of Sociology

<http://people.ku.edu/~rachelcr>

Phone: 314-643-7236

Email: herbalusestudy@ku.edu



Herbal Use Study Phone: 314-643-7236 Email: herbalusestudy@ku.edu									
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Appendix E: Template Email Solicitation Text

Dear <Name>,

My name is Rachel Craft, and I am a PhD student in the Department of Sociology at the University of Kansas in Lawrence. In my PhD Dissertation I am exploring why and how people use herbal medicine for health and well-being. As part of this research, I am currently interviewing adults in the <Cincinnati/St. Louis> Area who have used a diversity of herbal medicines in the past year.

I found <out about you/place> by way of <information/contact source>, and <indicate why I am contacting them/there>. I would be delighted to interview you, if you are interested and willing. The interviews generally take about two hours (though they can run shorter or longer depending on how much information you'd like to share) and consist primarily of questions about your use of herbal medicine. It would be very helpful for the interviews to take place where you grow, process, use, and/or get information about herbal medicine. I understand this may include your home or business, and want to assure you that all identifying information that I collect will remain confidential, all information collected will be discussed in my findings in a non-identifying manner, and that I am not at all concerned about the condition of your home or office. We may also interview at other locations, and you are free to decline to participate in all or any part of this research.

If you are interested in learning more about this research, please visit my website at <http://www.people.ku.edu/~rachelcr/>. If you are unable or unwilling to participate in this research but know of other locations where I may be able to recruit interview participants, or of adults in <Cincinnati/St. Louis> who have used a diversity of herbal medicine in the past year and may be interested in this research, please let me know and/or feel free to forward this information to them. Please contact me if you would like more information or if you are interested in participating in this research by way of email or phone (listed below). As the interviews are an integral part of my PhD Dissertation, I appreciate any help or guidance in finding people who use herbal medicine and are available and willing to interview with me.

Thank you for taking the time to review this request and for any help you may be able to provide.

Rachel Craft

rachelcr@ku.edu or herbalusestudy@ku.edu

314-643-7236

Appendix F: Facebook Recruitment Text

Do you use a diversity of herbal products or medicinal plants for health and well-being? I am a graduate student at the University of Kansas interviewing adults in the St. Louis Area to complete work on my PhD dissertation, which explores why and how people use plants as medicine. The interview could take up to two hours, and should cause no more discomfort than we experience in everyday life. If you are interested in participating in this research or have questions about the research, please see my website linked below for more information.

<http://www.people.ku.edu/~rachelcr/>

Appendix G: Interview Guide

Herbal Use Study Semi-Structured Interview Guide

Introduction Script: As you know, my name is Rachel Craft, and I am PhD student in the Department of Sociology at the University of Kansas. I have experience researching herbal medicine through my Graduate Research Assistantship with the Native Medicine Plant Research Project at the University of Kansas. During the course of my research I began to wonder why people are increasingly using herbs for health and well-being. So, I decided to research how people use herbs and herbal products for my PhD Dissertation. I am very excited to learn more about your experiences with and use of herbs and herbal products, and I hope that my research findings will shed light on the question of why people use herbs for health and well-being, and perhaps even inform policies regarding the public's use of herbs. Before we begin, I would like to review Consent to Participate documents with you. (Review consent documents and address any questions.)

I would like to begin by asking you a few questions about your use of different medical therapies and your health, then I would like to ask you about how you first started using herbal medicine. After that, I have a few more questions about how you continued to use herbal medicine, how you use herbal medicine, and I will ask for your thoughts about related topics, such as whether you believe there is a movement for herbal medicine in America. At the end of the interview, if possible, I would like to observe the process that you go through when you use herbal medicine, such as by viewing the herbs themselves, items that you use when preparing herbs, your garden, and any books or other information sources that guide you in the use of herbal medicine. I will also ask you to fill out a brief demographic survey and to identify what herbs are most important to you. Do you have any questions before we begin? Is it okay for me to begin audio recording?

Set 1: Herbs, Health, Diet, and Use of Medical Therapies

- 1) As you know this is a study on herb and herbal product use. When you hear the terms 'herb' and 'herbal product,' what do you think of, or what comes to mind? (Or, put differently, how would you characterize them, or what meaning do they have for you?) (Just to be sure we are talking about the same things.)
 - a) Is it exclusively medicinal plants or more? How are herbs distinguished from other dietary supplements and foods? Are there different categories of herbal medicines?
- 2) I'd like to learn more about the different medical therapies you use, as well as about the importance of herbal medicine to your health and well-being. I'd like to start by asking you about your diet and health.
 - a) How would you describe your diet and the kind of food you eat?
 - i) Are you vegetarian or vegan? Do you prefer to eat local, organic, or natural foods?
 - ii) From where do you get your food?
 - (1) Is this where you prefer to get your food? If not, from where, how?

- b) Sometimes on surveys they ask you to rate your health on a scale ranging from excellent to poor. How would you characterize your health on such a scale?
 - i) Why so?
- c) Do you also use vitamin or mineral supplements, or other non-vitamin non-mineral dietary supplements?
 - i) What kinds do you use? How often do you use them?
- d) How would you characterize your use of herbal medicine?
 - i) Approximately how many different plants and herbal products do you think you've used in the past year? Or, how many different plants and herbal products do you take in a typical day?
 - ii) Do you see an herbalist or other alternative practitioner(s)? How many, what kind, how often?
- e) What other types of medical therapies do you use?
 - i) Have you in the past year, or do you, see a medical doctor or other health practitioners?
 - (1) How would you characterize your last (few) experience(s)?
 - (a) As favorable, or not? Why so?
 - (2) Did/do you discuss your use of alternative therapies or herbal medicine with the doctor?
 - (a) Who brought it up? How do you believe they viewed your use?
 - ii) Do you practice other alternative therapies?
 - (1) Or other mainstream therapies?
 - iii) Do you use over the counter or prescription medication?
- f) How important is herbal medicine to your health and well-being? This can be in general or in relation to other therapies.
 - i) How would you gauge your reliance on plants for medicine? Do you believe these are more or less effective than other therapies?
 - (1) Do you prefer it over prescription medicine?
 - (2) Do you use it to complement or as an alternative to prescription medicine?
 - ii) When you travel, are there certain staple herbs you take with you?
 - (1) What would you do if they were lost or destroyed?

Set 2: Becoming a Medicinal Plant User

- 1) Can you tell me about how you first got involved in (or, what led you to) the use of herbal medicine?
 - a) Approximately how old were you, or around what year was that?
 - b) Why did you start using herbal medicine?
 - i) Were you skeptical that it would work?
 - (1) Why or why not?
 - c) What was the setting of your initial experiences with herbal medicine?

- d) Were there any influential people, books, or other social influences?
- e) What were the circumstances surrounding your first use of herbal medicine?
- 2) How would you characterize your evolution from the first time you used herbal medicine to where you are now?
 - a) Were there additional influences, situations, experiences, and so on that led you to continue using herbal medicine?
 - b) How did the way that you used herbal medicine change as you continued to use it?
 - c) How has your use of herbal medicine impacted the rest of your life?
 - i) For instance, have you made adjustments in your daily life? How so?
 - ii) Has there been a (concomitant) change in your worldview, or your way of seeing/approaching the world?
 - (1) For example, in how you approach or define medicine, health, and/or sickness?
 - d) Do you consider yourself an herbalist?
 - i) How so, how not?
 - ii) What do you think it means to be an herbalist? What characteristics would you ascribe to an herbalist?
 - e) How often do you talk about herbal medicine with family, friends, or others; and when you do, what kinds of things do you talk about?
 - i) Who do you talk to?
 - ii) In what instances/Under what circumstances?
 - (1) Do they come to you, do you volunteer it?
 - (2) What is the extent of your encouragement for others to use herbal medicine?
 - (3) About what percentage of the people that you talk do you think are receptive to your ideas about using herbal medicine?
 - iii) Can you provide an example of how you talk about herbal medicine with others?
 - f) How do you believe others perceive your use of herbs and herbal supplements?
 - i) Have you experienced any memorable or particularly positive or negative reactions?
 - (1) Who?
 - (2) How so?
 - g) (Review why they started using medicinal plants.) Can you think of any other reasons for why you started to, or currently, use herbal medicine? Are there any other influential experiences, people, ideas and so on that influenced your choice to use herbal medicine for health and well-being?

Set 3: Movements, Voting, and Cannabis

- 1) Do you believe there is a movement in America for alternative medicine? For herbal medicine?
 - a) How would you characterize the movement?
 - b) How would you characterize your affinity for/participation with the movement?

- c) What kinds of organizations, groups, or social causes do you support or agree with? How would you characterize your affinity for/participation with these?
- 2) I want to ask you a few questions that might seem controversial. Remember that you are free to decline to answer these and any other questions I ask you.
 - a) How do you feel about the legalization of marijuana?
 - i) What about for medicinal or recreational purposes?
 - b) Did you vote in the 2012 presidential elections?

Set 4: How Is Herbal Medicine Used

- 1) I am interested in learning more about how you use herbs and herbal products. You said you use # different herbs/herbal supplements. What are some of the most important ones you've used in the past year (up to 10)?
 - a) Fill out worksheet listing herbs, what they were used for, what forms they were used in.
 - i) How do you know if an herb or herbal supplement works (is effective)?
 - (1) Can you think of an example when you knew an herb/herbal supplement worked or didn't work?
 - ii) Have you ever had an adverse effect, herb-drug interaction, or some other untoward effect from using herbs?
 - (1) What happened? How would you characterize the adverse effect?
 - (2) Did you discuss this AE with anyone? (What was the outcome?)
- 2) I am also interested in learning more about how you learned to use herbal medicine. Can you describe the process you go through when you decide to start using a new herbal medicine?
 - a) For instance, with an example of how you started using one, perhaps the most recent, or one that you find among the most important.
 - b) Can you tell me more about from where or whom have you learned about other herbs/products that you use?
 - i) What are the information sources?
 - ii) What process do you go through to find out more information on using herbal medicine?
 - iii) How would you characterize the quality of information available to you?
 - (1) What sources do you believe are the most reliable (e.g., helpful and accurate) (or not)? Why?
 - (2) Are there any resources you would recommend to others?
 - (3) Have you had any difficulty finding reliable information on herbal use? Please describe them:
 - iv) Do you participate in any groups (in person or on-line) that discuss herbal medicine?
 - (1) Why/Why not? What/Who are they?
 - (2) What is the extent of your participation?
 - v) Can you think of any other important resources that have informed your choice to use herbal medicine or how you use them?

- 3) Can you show me how you go about using herbal medicine in a typical day?
- a) Can I observe how:
- i) You prepare and/or use herbs (some part of the process); your herb/supplement collection; your garden; other pertinent parts and props of the process, such as tea kettles, pill boxes/baskets, books and other texts.
- ii) May I take photographs of these?
- (1) You are free to say no at any time. I will ask before I take any pictures, and I am glad to show you the picture on my camera – if you do not want me to use the picture we can delete it from my camera. If it makes you more comfortable, you are welcome to use my camera to take photographs. As noted on the consent form, you can withdraw your permission to use the photographs in any publications before they are published, just let me, KU Sociology Dept., or HSCL know.
- b) Why do you prefer to use herbal medicine in this way, as opposed to other ways that people might use?
- i) Do you prefer or favor certain forms, contexts, settings, etc. for use? Or disfavor? Which ones? Why?
- (1) Do you believe that these different factors make an herbal medicine more or less effective? How so?
- c) Can you describe what factors you consider when selecting an herbal medicine?
- i) (Let participants know that I am gathering this information to understand more about how they use herbal medicine and will not report this information in a way that could be used for advertising purposes.)
- ii) E.g., For instance, why chose this particular ... over other ... available to you?
- iii) E.g., trusted sources, brands; freshness of plant; price; quality; taste; local
- d) Are there other thoughts about the way you use herbs/herbal supplements that you believe are important, or about the effectiveness of herbal medicine? Are there other important factors that have informed your choice to use herbs/herbal supplements or the way you use them?
- ❖ Could I ask you to fill out a brief demographic survey? If there are questions you do not want to answer, please leave them blank.
- ❖ This concludes the interview. BIG Thank you. Are there any questions that I didn't ask, that perhaps you think I should ask or that you anticipated/expected?
- ❖ Any questions for me?
- ❖ Another thank you for the time and energy taken to interview. Confirm contact information, ask to pass along card/web/flyer to others, ask if okay to follow up with questions or an online survey. Would be glad to be in touch with anything that is published. Please contact with any questions about study and participation.

Appendix H: Frequency Distribution of Most Important Herbal Medicines

Table A.1: Frequency Distribution of Most Important Plants Indicated by Participants (n=25)

Herbal Medicine Name	Count	Herbal Medicine Name	Count
Herbal Blends and Formulas*	36	Blackcurrent	1
Other Dietary Supplements**	17	Black tea	1
Essential Oils***	9	<i>Boswellia</i>	1
Garlic	7	<i>Cannabis</i>	1
Nettles	7	Catnip	1
<i>Echinacea</i>	6	Chamomile	1
St. John's wort	5	Chinese licorice	1
Comfrey	4	<i>Coleus</i>	1
Elderberry	4	Coltsfoot	1
Linden flower	4	Elecampane	1
Mullein	4	<i>Eucalyptus</i>	1
Plantain	4	Evening primrose oil	1
Red clover	4	Fennel	1
Slippery elm	4	Fenugreek	1
Ashwagandha	3	Fermented chia seed	1
Cayenne	3	Feverfew	1
Chickweed	3	Flax seed oil	1
Coconut oil	3	Forskolin	1
Dandelion	3	<i>Ginkgo</i>	1
Ginseng	3	Guggul	1
Hawthorn berry	3	Gynostemma	1
Mints	3	Hemp	1
Oat straw	3	Holy basil	1
Red raspberry	3	Hops	1
Tumeric	3	Hyssop	1
Valerian	3	Jewelweed	1
Yarrow	3	Lady's mantles	1
<i>Astragalus</i>	2	Lavender	1
Butcher's broom	2	Maca	1
Cinnamon	2	Milk thistle	1
Damiana	2	<i>Moringa</i>	1
Dong quai	2	Motherwort	1
Ginger	2	Olive leaf extract	1
Goldenseal	2	Oregon grape root	1
<i>Hybiscus</i>	2	Osha	1
Lemon balm	2	Passion flower	1
Reishi mushroom	2	<i>Rhodiola</i>	1
Rosemary	2	Sage	1
<i>Vitex</i>	2	Sea buckthorn oil	1
Alfalfa	1	Skullcap	1
<i>Aloe</i>	1	Noni juice	1
<i>Arnica</i>	1	Thyme	1
Bayberry	1	Violets	1
Bitters	1	White pine	1
Black cohosh	1	Wild yam	1

Table A.1 Notes:

* Herbal Blend and Formula use was indicated by 16 participants. These consisted of 3 or more medicinal plants in a combination tea, salve, capsule, or other form. Herbal combinations were used for things like stress, sleep, the spleen, reproduction, metabolism, lactation, allergies, prostate health, and more.

** Dietary Supplement use was indicated by 8 participants. These consisted of vitamins, minerals, and nonvitamin and nonminerals such as probiotics, omegas, and CoQ10.

*** Essential Oil use was indicated by 7 participants, and included lavender oil, rose oil, Jasmine oil, Sandlewood oil, and patchouli oil.

Appendix J: Demographic Survey

Herbal Use Demographic Survey

1. Please indicate your geographical location:
 - Lawrence, KS
 - Cincinnati, OH
 - St. Louis, MO
 - Other: _____
2. How many years have you lived here?

3. In what city and state were you born?

4. In what year were you born?

5. Please indicate your primary ethnicity:
 - White (not Hispanic)
 - Hispanic or Latino
 - Native American
 - Two or more ethnicities (please indicate): _____
 - Other (please indicate): _____
 - Black
 - Asian
 - Pacific Islander
6. Please indicate your gender:
 - Male
 - Female
 - Transgendered
7. Please indicate your highest level of education:
 - No formal education
 - Less than high school
 - Some high school
 - High School or GED
 - Some college
 - Trade/Technical/Vocational Training
 - Other (please indicate): _____
 - Associate's Degree
 - Bachelor's Degree
 - Master's Degree
 - Doctoral Degree
 - Professional/Technical Degree (MD, JD)
8. If a college degree was granted, please indicate your primary field of study:

9. Please indicate your employment status during the past month:
 - Employed Full-time
 - Employed Part-time
 - Self-employed
 - Unemployed
 - Retired
 - Other (please indicate): _____
 - Student
 - Full-time Homemaker
 - Seasonal
 - Temporary
 - Disabled
10. Please indicate your primary occupation:

11. Including yourself, how many people live in your household?

13. What is your relationship status?
- Single
 - In a relationship
 - Living with Partner (cohabitating)
 - Married; Have Partner
 - Divorced
 - Widowed
 - Separated
14. What is your total individual yearly gross income before taxes?
- \$0-20,000
 - \$20,001-40,000
 - \$40,001-60,000
 - \$60,001-80,000
 - \$80,001-100,000
 - \$100,001-150,000
 - \$150,001+
 - Prefer not to say
15. What is your total household yearly gross income before taxes?
- \$0-20,000
 - \$20,001-40,000
 - \$40,001-60,000
 - \$60,001-80,000
 - \$80,001-100,000
 - \$100,001-150,000
 - \$150,001+
 - Prefer not to say
16. To what extent do you consider yourself a religious person? Are you...
- Very religious
 - Moderately religious
 - Slightly religious
 - Not religious at all
 - Do not know
17. Please indicate your religious affiliation:
- Protestant
 - Jewish
 - Mormon
 - Catholic
 - Muslim
 - Other (please specify below)
18. Please specify your denomination: _____
19. Aside from weddings and funerals, how often do you attend church, synagogue, mosque, or some other religious services?
- More than once a week
 - Once a week
 - Once or twice a month
 - A few times a year
 - Seldom
 - Never
 - Do not know
20. To what extent do you consider yourself a spiritual person?
- Very spiritual
 - Moderately spiritual
 - Slightly spiritual
 - Not spiritual at all
 - Do not know
20. Do you formally belong to a political party?
- Yes, Republican
 - Yes, Democratic
 - Yes, another party (please indicate): _____
 - Yes, Libertarian
 - No, I am not a party member
21. Whether or not you belong to a political party, please indicate where you stand generally:
- Lean strongly toward the Republicans
 - Lean moderately toward the Republicans
 - Lean slightly toward the Republicans
 - Do not lean toward either the Republicans or the Democrats
 - Lean slightly toward the Democrats
 - Lean moderately toward the Democrats
 - Lean strongly toward the Democrats

Appendix K: Demographic Results

Table A.2: Results of Demographic Analysis by City

	Cincinnati, OH	St. Louis, MO
<u>Age</u>		
18-25	-	2
26-35	1	2
36-45	7	2
46-55	3	1
56-65	2	4
66-75	1	2
Not Specified	-	1
<u>Gender</u>		
Male	3	3
Female	11	11
Transgendered	-	-
Not Specified	-	-
<u>Race</u>		
White	12	12
Black	1	
Mixed Race	1	1
Not Specified	-	1
<u>Highest Degree of Education</u>		
High School/GED	-	1
Some College	3	2
Trade/Technical/Professional degree	3	2
Bachelor's	3	3
Master's	5	6
<u>Degree of Religiousness</u>		
Not Religious at All	8	5
Slightly Religious	-	1
Moderately Religious	2	1
Very Religious	1	2
Do Not Know	-	1
Not Specified	3	4
<u>Degree of Spirituality</u>		
Not Spiritual at All	-	-
Slightly Spiritual	-	1
Moderately Spiritual	2	2
Very Spiritual	12	11
<u>Political Stance</u>		
Lean strongly toward the Republicans	1	-
Lean moderately toward the Republicans		-
Lean slightly toward the Republicans	1	-
Do not lean toward either the Republicans or the Democrats	6	3
Lean slightly toward the Democrats	-	-
Lean moderately toward the Democrats	3	4
Lean strongly toward the Democrats	-	6
Other	1	-
Not Specified	1	1

Appendix L: List of Thematic Codes

Categorical Codes	Thematic Codes	Sub-Thematic Codes
Story and <i>Evolve</i>	Childhood	Experiences in nature
		Parents' use
		Grandparents' use
		Ancestors' traditional use
	Adulthood	CAM interest
		Other interests
		Influential people
		Influential texts
		Social movement influence
		Influential places
		Work experiences
		Herbs were effective
<i>Experiential knowledge</i>		
<i>Knowledge sources</i>		
<i>Professional practice</i>		
<i>Herbal education</i>		
Situational conditions	<i>Illness experiences</i>	
	<i>Health insurance</i>	
	<i>Pregnancy</i>	
Western Medicine Dissatisfaction	Doctor-patient interactions	Acceptance of diagnosis
		Quality of interaction
		Lack of answers to questions posed
		Nocebos; Fear
		Acceptance of prognosis
	No need to see doctor	
	Ineffective Treatment	Unable to accurately diagnose
		Treatment was not effective
	Risk of Treatment	Adverse effects
	Accessibility	Western medicine unavailable
		Western medicine unfeasible
	Pharmaceutical concerns	Side effects
Not natural		
Less safe than herbs		
Overused; Misused		
Unsustainable		
Medicalization		
Advertising		
Doesn't Cure		
Place of Western Medicine	Extent of Western medicine use	
	Emergency situations	
	Pain	
	When herbs don't work	
	When herbs aren't a good fit	
	Diagnostics	
	Prevention	
	Integration	

Codes Identified But Not Included in this Analysis	
Categorical Codes	Thematic Codes
Herb Use	Number of herbs used
	Most important herbs
	Form preference
	Brand preference
	Efficacy
	Resources used
Impact on Life	Diet
	Lifestyle
	Holism
	Health
	Worldview
	Social
Becoming an Herbalist	Self identification
	Good herbalists
	Desire to help others
Obstacles in Use	Lost knowledge
	Little social networks
	Information accessibility
	Information quality
	People don't know option
	Money and time
	FDA and industry
Talking to Others	Receptivity
	Negative experiences
	Doctors
Herbs Defined	
Import of Use	
Use of CAM and DS	
Diet	
Health	
Social Movement for CAM	
Social Movement Involvement	
Voting	
Legalization of <i>Cannabis</i>	

Appendix M: Influences on Participants' Choice to Use Herbal Medicine

Table A.3: Childhood Influences and Experiences

Participant Name	Childhood Influences and Experiences			
	Experiences in Nature	Parent Use	Grandparent Use	Traditional Cultural Use
Maggie	X			
Theresa				
Carol				
Bob	X			
Andrea		X	X	X
Morgan				
Lilly	X			
Tom		X	X	
Tara	X			
Jessica			X	X
Alaina				
Tory				
Zoe				
Jody			X	
Angie	X			
Eileen				X*
Jeanette				
Molly		X		
Allen				
Betty				
Monica	X	X	X	X
Alisha				
Glen				
Mary				X*
Steven			X	
Denise				
Joan	X			X
Amanda		X		

* Indicates influence not related to familial history

Table A.4: Adulthood Influences and Experiences

Participant Name	Adulthood Influences and Experiences				
	CAM Interest	People	Texts	Move-ments	Work
Maggie			X		X
Theresa		X*			
Carol			X*		
Bob		X			
Andrea	X		X		
Morgan		X*			
Lilly			X*		
Tom		X*			
Tara		X	X*		
Jessica			X	X	
Alaina	X	X			X
Tory	X	X	X*		
Zoe		X*			
Jody	X		X		
Angie		X	X	X	
Eileen		X*		X*	
Jeanette		X*			
Molly		X	X*	X	
Allen		X*			
Betty	X		X		
Monica					X
Alisha	X	X*			
Glen			X*		
Mary		X*	X*	X*	
Steven			X		X
Denise	X	X	X		
Joan				X	
Amanda		X			

* Indicates reference to influence following a situational condition

Table A.5: Situational Circumstances

Participant Name	Situational Circumstances			
	Health Insurance	Health Need	Diagnosis	Pregnancy
Maggie				X
Theresa	X	X*	S/L	
Carol		X*	S/DR	
Bob		X	S/DR	
Andrea				X
Morgan		X*	S/DR	
Lilly	X			
Tom		X	DR	
Tara				X
Jessica				X
Alaina				
Tory		X*	S	
Zoe		X	S/L	
Jody				
Angie				
Eileen		X*	S/L	
Jeanette		X	DR	
Molly				X
Allen		X	DR	
Betty				
Monica				
Alisha	X			
Glen		X	DR	
Mary		X	DR	
Steven		X	DR	
Denise				
Joan				
Amanda				X

* Indicates a contested illness experience

S= self-diagnosed; L= lay diagnosis; DR = diagnosed by a MD

Table A.6: Western Medicine Dissatisfaction

Participant Name	Western Medicine Dissatisfaction			
	Doctor-Patient	Ineffective Treatment	Risks of Treatment	Not Accessible/ Poor Fit
Maggie				
Theresa				X
Carol		X		
Bob				X
Andrea				
Morgan		X		
Lilly				X
Tom	X		X	
Tara				
Jessica				
Alaina				
Tory		X		
Zoe				X
Jody				
Angie				
Eileen		X		
Jeanette	X		X	
Molly				
Allen	X			
Betty				
Monica				
Alisha				X
Glen	X			
Mary		X		
Steven	X			
Denise				
Joan				
Amanda				

Table A.7: Pharmaceutical Concerns

Participant Name	Pharmaceutical Concerns							
	Side Effects	Not Natural	Less Safe	Overused; Misused	Not sustain-able	Medicali-zation	Adver-tising	Doesn't Cure
Maggie	X	X	X				X	X
Theresa	X	X	X			X	X	X
Carol	X	X						X
Bob	X					X		X
Andrea	X	X	X	X			X	X
Morgan				X	X		X	X
Lilly			X	X			X	X
Tom		X	X				X	
Tara			X					
Jessica				X				
Alaina								
Tory	X		X	X			X	
Zoe	X	X	X	X				
Jody				X	X			
Angie					X			
Eileen	X	X	X					X
Jeanette	X	X	X			X		X
Molly		X	X	X		X		X
Allen				X				
Betty	X	X	X					
Monica	X			X				
Alisha		X				X		
Glen							X	X
Mary	X	X	X				X	
Steven	X		X			X		
Denise	X		X					
Joan	X							
Amanda		X	X	X			X	