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**Beyond Hypericum:
Perceptions of Treatments by Herbalists for Depression**

A thesis
submitted in fulfillment
of the requirements for the degree
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by

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Abstract

Complementary Alternative Medicine (CAM) includes a diverse range of traditional and natural treatments practiced beyond orthodox medical practices. CAM therapies are used globally by consumers and rates of use are increasing. Medical herbalists are a group of CAM therapists who are trained in the practice of holistic healing to restore homeostasis via a number of modalities including herbal medicines, diet and nutrition and various mind and body techniques.

Six women who had consulted medical herbalists for symptoms of low mood/depression were interviewed. Questions focused on: why the participants chose to visit a herbalist; contextual factors surrounding the participants at the time; what their treatment programs entailed; their perceptions of symptom relief, efficacy and the therapeutic relationship; perceived barriers to accessing these types of services and the long term implications the treatments had for the women.

Overall, the women felt that the holistic treatments they received had been effective for low mood/depression. It also was evident that the quality of the therapeutic relationship contributed significantly to perceptions of efficacy. Furthermore, practitioners' holistic explanations about illness fostered participants' understanding of health issues, thereby encouraging patient autonomy over personal health care. The participants continue to utilize CAM therapies and medical pluralism for themselves or their children. As well, two participants engaged in CAM studies for professional or personal use.

On the other hand, the cost of treatment was a strong disincentive, almost making treatments inaccessible for some. An additional barrier to accessing CAM was the widely held negative stereotyped attitudes about herbalists. It was thought that if CAM treatments were more widely accepted and subsidized, they would be a more realistic choice for health consumers.

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INTRODUCTION

I began this research having had eight years as a psychology student and fourteen years as a Complementary Alternative Medicine (CAM) practitioner; specifically, a Medical Herbalist. As a psychology student in a part time herbal practice, I became increasingly intrigued by the amount of people who would attend my clinic with symptoms of low mood or depression. Knowing that I would be engaging in a Masters degree prompted me to contemplate people with low mood who utilize Medical Herbalists for their symptoms. If people were presenting frequently to my practice with low mood, then presumably they were also presenting to other herbalists with low mood or depression.

CHAPTER ONE: COMPLEMENTARY ALTERNATIVE MEDICINE (CAM)

Complementary Alternative Medicine (CAM), covers a broad spectrum of medical practices around the world. CAM therapies as defined by The World Health Organisation Traditional Medicine Strategy 2002 - 2005 (WHO, 2002) includes; diverse health approaches and practices, knowledge and beliefs which include plant, animal or mineral based medicines, spiritual therapies, manual techniques and exercises applied as diagnosis or treatment for well being and the prevention of ill health. The New Zealand Ministry of Health refers to CAM as *'health care provision not generally part of the main stream system of health'* (MOH, 2003: pg 163). CAM includes a diverse range of natural treatments and modalities practiced beyond conventional medical practices (Ministerial Advisory Committee on Complimentary and Alternative Health (MACCAH), 2004; National Centre for Complimentary and Alternative Medicine (NCAM), 2007). This includes the practices of: Osteopathy, Aromatherapy, Rongoa Rakau, Herbal medicine, Homeopathy, vitamin and nutritional therapies and massage (MACCAH, 2004; NCAM, 2007).

Globally, there has been a profound increase in the utilization of CAM over the past thirty years (Brems, Johnson, Warner & Roberts, 2006; Cartwright & Torr, 2005; Furnam, 2002; Mackenzie, Taylor, Bloom, Hufford & Johnson, 2003; Rascoe, Forjuoh, Couchman, Reis, O'Kirkpatrick & Van Walsum, 2004; Tindle, Davis, Phillips & Eisenberg, 2005; Wolsko, Ware, Kutner, Lin, Albertson, Cyran, Schilling

& Anderson, 2000; WHO, 2001). It is estimated that 75 - 80 % of the world's population utilize CAM and for many this is primary health care (Hughes, 2007; WHO, 2001). New Zealand statistics demonstrate that one in four New Zealanders over fifteen years of age use CAM (MOH, 2004). Efficacy of CAM treatments is acknowledged for mental health, chronic conditions, prevention of diseases and non - communicable diseases; however, the lack of a scientific evidence base is argued (Furnam, 2002; Kune & Kune, 2005; MacLennan, Wilson & Taylor, 1996; MOH, 2006; WHO, 2001). Depression, insomnia and anxiety are reported as being the most common conditions for consumer visits to CAM practitioners in the United States of America (Pilkington, Rampes & Richardson, 2006). In a survey of CAM use in the USA in the year of 2000, 22.4% of 9585 respondents met criteria for Major Depressive Disorder and in many cases consumer preference is evident for CAM therapy for depression (O' Higgins, Glover & Corral, 2005; Pilkington et al, 2006; Rascoe et al., 2004; Wu, Fuller, Liu, Lee, Fan, Hoven, Mandell, Wade & Kroenberg, 2007).

Depression

Depression is a mental illness experienced by 15% of the population of most developed countries in the world (Murray & Fortinberry, 2005; World Health Organization, 2006). Depression is experienced by approximately one in five New Zealand women and one in ten New Zealand men (Mental Health Foundation of New Zealand (MHF), 2007). In America, women experience depression at a rate of 10–20% over a lifetime in comparison to 5–10% for men. Prevalence rates at approximately 16% of the American adult population (Hawton, Salkovskis, Kirk & Clark, 1989; Linde, Mulrow, Berner & Egger, 2005). Symptoms of depression are heterogeneous manifesting differently but comparably for individuals, with a loss of pleasure in most activities or depressed mood deemed as pivotal (MHF, 2007; National Institute for Health and Clinical Excellence (NICE), 2004; Pilkington et al., 2006; WHO, 2005). People experiencing depression or low mood may present with any number of symptoms such as; fatigue or reduced energy levels, sleep disturbances, appetite or weight change, sadness or crying without knowing why, loss of interest in activities previously deemed to be pleasurable, a persistent low mood or emotional numbness, feelings of irritability, anxiety, agitation or worry, loss of libido,

lack of concentration or forgetfulness, feelings of guilt, hopelessness or worthlessness, suicidal ideation or suicide (Carr & McNulty, 2006; DSM-IV-TR, 2000; Hawton et al., 1989; Leahy & Holland, 2000; MHF, 2007; WHO, 2005). Reasons for why people experience depression are generally dependant on circumstances relative to a person; however, some common factors are ascertained (MHF, 2007).

Depression may be precipitated by a significant life event or by multiple causative factors (Hawton et al., 1989; MHF, 2007). A particular life event involving a perceived loss, such as; the break up of a relationship, an injury or illness or work, and financial stresses may trigger depression, while many women experience depression after childbirth (Carr & McNulty, 2006; Leahy & Holland, 2000; MHF, 2007). O'Higgins et al (2005) cite between 10 -15% of all women experience post natal depression after giving birth. Furthermore, biological theories suggest that some individuals are predisposed to depression, with heritability rates estimated to be between 40-70% (Carr & McNulty, 2006; Hawton et al, 1989). Personality traits such as those seen in individuals with poor problem solving abilities and pessimistic cognitive styles may also be contributory to depression (Carr & McNulty, 2006; Hawton et al, 1989; Leahy & Holland, 2000; MHF, 2007). Whatever the precipitants or predisposing factors, depression is a debilitating disorder for those who experience it. Fortunately, when depression is recognized and treatment is obtained, relief may be experienced (Carr & McNulty, 2006; Leahy & Holland, 2000; MHF, 2007).

Various treatments exist for depression. Commonly used are pharmacological treatments such as anti-depressant medications prescribed by medical practitioners or psychological therapies administered by psychologists, such as; Cognitive Behavioural Therapy, Interpersonal Therapy, Mindfulness Based therapy and Systemic Therapy (Beck, 1995; Carr & McNulty, 2006; Curwen, Palmer & Ruddell, 2000; Hawton et al., 1989; Leahy & Holland, 2000; Padesky & Greenberger, 1995; Seagal, Williams & Teasdale, 2002; Weissman, Markowitz & Klerman, 2007). Pharmacological treatments, Cognitive - Behavioural Therapy and Interpersonal Therapy for depression are supported by a strong evidence base (Carr & McNulty, 2006; Curwen et al, 2000; Datillio, 2003; Hawton et al, 1989; Leahy & Holland,

2000; Padesky & Greenberger, 1995; Pilkington et al., 2006; Segal et al, 2002). The NICE (2007), however; discuss that anti-depressant medications are not recommendable in mild depression due to risk - benefit ratios. Multi-modal methods combining pharmacological and psychological treatments demonstrate efficacy in some situations (Carr & McNulty, 2006; Hawton et al, 1989; Leahy & Holland, 2000; Padesky & Greenberger, 1995). Very often a change of lifestyle and engaging in pleasurable activities is facilitative to well being and relief of depressive symptoms; whereas, others prefer to engage in Complementary Alternative therapies which have been perceived as efficacious by some CAM consumers (Murray & Fortinberry, 2005; Roy – Byrne, Bystritsky, Russo, Craske, 2005; Wu et al., 2007).

Complementary Alternative Medicine and Depression

CAM is frequently chosen for depression through various modalities, such as; Acupuncture, Aromatherapy, Yoga, Herbal Medicine, Meditation, Chiropractor therapy, massage, relaxation techniques and Homeopathy (Kune & Kune, 2005; NICE, 2007; Pilkington, et al., 2006; Roy – Byrne et al., 2005; Saks, 2005). Research into CAM use for depression is limited but an increasing interest in this area is contributing to more reviews on its efficacy and public choice for these services (MacLennan et al., 1996; Pilkington et al, 2006). While some choose CAM as an adjunct to more conventional treatments, others seek CAM as a first choice (O’Higgins, Glover & Corral, 2005; Roy – Byrne et al, 2005; Wu, et al., 2007). When depression is mild and it is apparent that risk of harm to self or others is not a factor, consideration should be given to a person’s choice of treatment (Pilkington, et al., 2006). With a range of therapies for low mood and depression available, client matching to choice may be an option that serves to be equally efficacious with regard to treatment outcome (Pilkington et al, 2006).

Although anti depressant medications and Cognitive-Behavioural Therapy rate as incomparably superior to CAM for depression; many seek CAM therapies with findings demonstrating participants perceive improvement to low mood status (Cott, Rosenthal, Blumenthal & Fomous, 2001; Pilkington et al, 2006; Sarris, 2007). Respondents in Rascoeet al’s (2004) study, reported preferences for natural medicines over chemical based Selective serotonin uptake reinhibitors - SSRI’s. One a third of

the participant sample ($n = 1,299$) had experienced negative perceived self efficacy when taking SSRI's and reported improvements in mood without negative side effects (Rascoe et al, 2004). Preference for herbals over pharmaceuticals was such that respondents did not deem cost to be a factor and were willing to pay out of their own pockets for CAM even when receiving funding for pharmaceutical medicines (Rascoe et al, 2004).

Wu, et al (2007) support these findings amongst female consumers of CAM for depression. Two hundred and twenty respondents participated in their survey of women with depression, with 54% of the sample having previously visited CAM practitioners for treatment of depressive symptoms (Wu et al, 2007). The most frequent treatment preferences reported in the survey were for natural approaches that were effective and free of side effects. Forty five percent cited negative side effects from pharmacological treatments with 43% finding conventional medicines to be ineffective (Wu et al, 2007). Wu et al (2007) discussed that belief systems rated highly amongst the participant sample with participants desiring treatments to be compatible with personal values. This was particularly evident for women who visited medical herbalists as their choice of CAM practitioner. Wu et al (2007) determined through their study that women with depression are frequent consumers of CAM therapies and in particular utilize herbal medicines, nutritional supplements and manual therapies. Further studies into CAM have explored the demographics of the consumers of CAM.

Consumers of Complementary Alternative Medicines

Research into the demographics of CAM consumers has been conducted on a global scale. For a long time the use of CAM has been associated with lower income, lower education, ethnic and religious minorities. It has been suggested that as orthodox medicine becomes more accessible to all, alternative therapies may become less patronized (Mackenzie et al., 2003). This however, has not been the case and since the 1980's CAM use has become prevalent amongst those with higher socio economic status, higher levels of education and non - indigenous groups (Mackenzie et al., 2003). In the United States of America, the United Kingdom, Australia and New Zealand, between 20 - 44% of the population use CAM each year (Brems et al,

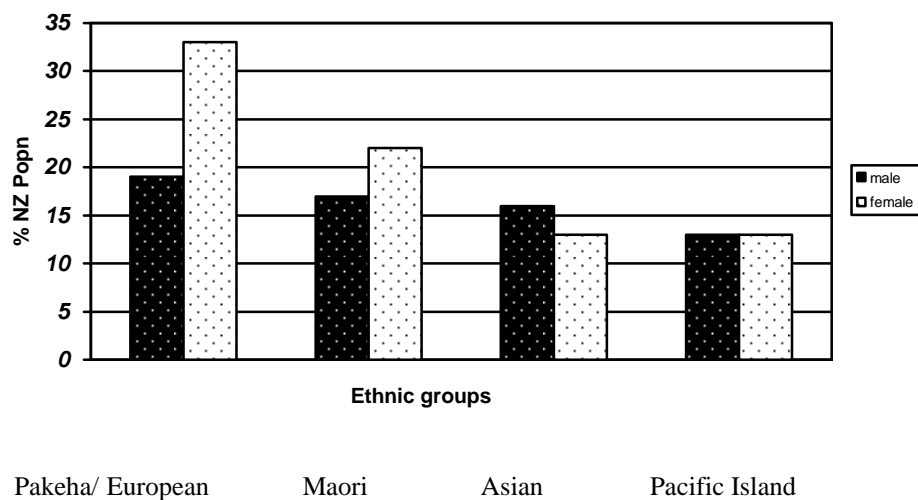
2006; Furnam, 2002; Kirmayer, 2004). Consumers of CAM vary their choice of treatments with Yoga and Herbal Medicine reported as the most popular (Tindle et al, 2005). Modalities such as chiropractic treatments have been reported as preferable amongst Europeans; whereas, herbal medicine is found to be more prevalent amongst Asian and Native Americans (Mackenzie et al, 2003; Tindle et al, 2005).

Further studies conducted in the United States of America establishing CAM demographics, report factors such as; gender i.e., being female, age 25 - 49 years, higher socio economic status, education, being uninsured and non-indigenous ethnicity as predictors of CAM consumers (Blais, Maiga & Aboubacar, 1997; Mackenzie et al, 2003; Garrow & Egede, 2006; Tindle et al., 2005; Wu, et al., 2007). To the contrary, Wolsko et al, (2000) conducted surveys in the USA and discuss in their findings that CAM use is not confined to any particular income or educational level, ethnicity or age, but that gender; i.e., being female and lower self-rated health status were predictors to visiting a CAM therapist. Wolsko et al (2000), discuss that although no significant differences between socio economic groups were established, those from lower socio economic status were less agreeable to visit CAM practitioners due to cost factors. Therefore, it may be intimated that expense is possibly a deterrent to seeking CAM therapies for those with a lower income.

Canadian studies have also demonstrated similar findings. High income, higher education levels, and being female were reported as indicators for Complementary Alternative Medicines (CAM) users, with a prominent age group between 45 - 64 years (Millar, 1997). Millar (1997) also discusses regional differences and hypothesizes this to be due to regional health care funding. Some areas such as British Columbia and the Prairies provinces of Manitoba, Saskatchewan and Alberta where provincial health care systems partially fund for some CAM services, demonstrate higher rates of CAM patronization (Millar, 1997). Further research carried out by Blais et al., (1997), explored users and non-users of CAM in Canada and found that although these two groups reported similar self perceptions relative to their health status, users of CAM actually had better health habits as well as general health. More recent research conducted into the Australian population of CAM users support findings into age, gender, education and good general health but add to these

demographics with rural CAM users being more prevalent than urban CAM users (Brems, et al., 2006; McLennan et al., 1996). Demographics for New Zealand/Aotearoa consumers of CAM are limited; however, key results from the New Zealand Health survey (2004) support previous findings with females being more likely to visit CAM practitioners than males.

Figure 1: Demographics of NZ/Aotearoa CAM consumers - 2004



Of these New Zealand/Aotearoa CAM consumers, 61.8 – 64.2% were recorded as being very satisfied with their CAM consultations and treatments and 33.6 – 35.9% reported being adequately satisfied (New Zealand Health Survey, 2004). Reasons why consumers sought CAM treatments varied throughout all demographic populations.

Reasons for Complementary Alternative Medicine use

Consumers of CAM visit CAM practitioners and Medical Herbalists for a range of physiological and psychological health issues (MOH, 2006; WHO, 2001). Various reasons for people's preferences for CAM are suggested. These include not only the physiological effects of medicines, but psychological, social and cultural approaches inherent to CAM appear to contribute to meaning for people and increase a sense of autonomy over healing (Bone, 2001; Brems et al., 2006; Francis, 2005; Furnham,

2002; Kirmayer, 2004; Linde et al., 2005; Brems et al, 2005; Saks, 2005; Xu, Luo & Tan, 2004; Yarnell & Abascal, 2001).

The most common reasons to visit CAM practitioners reported are: recommendations by family or friends, media influences, autonomy over treatment decisions, preferences for medications with less negative side effects, long consultations, practitioner empathy, personalization, counseling, hope of cures for chronic conditions, perceived congruence with personal beliefs and philosophies, a focus on health as opposed to disease and perceived efficacy of treatment (Astin, 1998; Brems et al, 2006; Ernst, 2000; Furnam, 2002; Garrow & Egede, 2006; Kune & Kune, 2005; MacLennan et al., 1996; Tindle et al., 2005). Positive previous experiences of a particular CAM practitioner or other previous CAM practitioners for past illness, was also suggested as a reason for people to choose CAM (Williams and Calnan, 1996). For most money was not an influencing factor for their choice of a CAM treatment (Cartwright & Torr, 2005; Rascoe et al., 2004). Key results of the New Zealand Health survey (Ministry of Health, 2004) cite the main reasons for people's choices of CAM practitioners as being;

- CAM practitioners were able to treat conditions other practitioners were unable to treat (50.7%)
- Referral from a friend or relative (29.2%)
- Referred by a doctor (12.0%).

The most prevalent reasons for going to CAM practitioners cited in the New Zealand Health survey (Ministry of Health, 2004) were;

- A chronic illness or condition 32.5%
- A temporary condition or short term illness (28.3%)
- Poisoning and injuries (23.9%)

These findings differ substantially to previous work by Astin (1996). Astin (1996) researched consumers of CAM in the United States of America. His results suggested key reasons for people's preferences towards using CAM practitioners as;

- Symptom relief and perceived efficacy was a primary motivation for consumers using CAM treatments. This was cited almost 50% more often than any other reason with a prevalent response being that “alternative methods promote health rather than just focus on illness” (Astin, 1996; pg 1552).
- A personal philosophical orientation towards holistic health. Perspectives held were that health needs to be approached from a platform of treating mind, body and spirit. This perspective overlapped with consumers identifying with cultural dimensions, commitment to feminism, commitment to environmentalism and personal growth psychology or spirituality (Astin, 1996).
- Culture was described as being a predictor of choice for alternative treatments. Alternative practices are often transmitted through cultures; therefore, were described as being cultural as well as philosophical (Astin, 1996).
- Dissatisfaction with conventional medicine was not reported as being a potential determinant for CAM use (Astin, 1996).

Furnam (2002), supports research into choices for CAM treatments by categorizing them into general reasons as purported by bodies of researchers. Furnam (2002) asserts that;

- *sociologists* suggest consumer and patient rights, post-modernist beliefs and holistic movements.
- *economists* argue the cost factors to clients as comparative to doctors and health insurances.
- *psychologists and psychiatrists* argue interpersonal reasons for people.
- *medical practitioners* discuss the benefits of longer consultations provided by CAM practitioners as well as a digression from standard scientific beliefs.

Although Furnam (2002) provides these categories, he also discusses that overarching reasons for consumer choice of CAM treatments are personal health beliefs, personal circumstances and dissatisfaction with medical practitioners. In many cases to obtain maximum levels of well being via the most appropriate methods for the consumer and their condition or where competition between medical approaches exists, CAM

users often may employ pluralistic approaches (Fabrega, 1997; Garrow & Egede, 2006; Islam, 2005).

Pluralistic approaches

Researchers O'Connor et al (2000) and Roy – Byrne et al (2005), discuss CAM and its dichotomous title. O'Conner et al (2000) suggests the term 'alternative' may be misleading as it implies an 'either or' category, as opposed to 'complementary', which in turn implicates corresponding systems alongside other forms of treatments (O'Conner et al., 2000; Roy – Byrne, et al., 2005). O'Connor et al., (2000) draws upon the experiences of patients and feels the later title 'complementary' is more representative of why people choose to use CAM, signifying a 'pluralistic' approach. This approach incorporates more than one medical modality being used alongside another, representing a holistic mode (Fabrega, 1997; Fox, 2005; Islam, 2005; Hsiao, Ryan, Hays, Coulter, Anderson & Wenger, 2006; Kune & Kune, 2005; WHO, 2002). Furthermore, Blais et al (1997) report as many as 83-88% of CAM users also use pluralistic methods for health treatments and the New Zealand Health Survey (2004) recorded one in three who visit a CAM practitioner also visit their GP's for the same conditions. It has also been purported that newer CAM users are more likely to use pluralistic methods whereas long term CAM users generally depend on CAM alone (Sirois, 2002).

As many choose medical pluralism, the Ministerial Advisory Committee on Complimentary and Alternative Health (MACCAH, 2003), advocates for research into pluralistic approaches so that various modalities may be facilitated safely and successfully in a truly complementary way. Notable advances within pluralistic health care have occurred in the United Kingdom after the House of Lords Science and Technology Select Committee conducted an enquiry into complimentary medicine and received a grant from the King's Fund to advance its regulation program (Fox, 2005; Lewith, et al, 2006). This resulted in statutory regulations for acupuncturists and herbalists at the same levels as nurses and doctors, with the aim for capacity building and trust between the professions (Fox, 2005; Lewith, et al., 2006). Emerging from this has been the ongoing development of CAM therapies within palliative care as well as 14 universities being involved in CAM research (Fox, 2005;

Lewith et al, 2006). Cartwright and Torr (2005) however, argue that positive effects of CAM treatments arising out of contributing factors such as the longer consultation times perceived by consumers as facilitative to treatment outcomes, may be compromised in an orthodox medical system. Despite debate, both orthodox medical and CAM approaches demonstrate advantages and disadvantages over each other and medical pluralism appears to be a sound way for people to gain access to multiple cultural approaches to healing (Fox, 2005; Mackenzie et al., 2003; Taylor et al, 2003). It has even been suggested that CAM is the early development of pluralistic systems representing integrated approaches of health treatment models (Lewith et al., 2006).

MODELS OF HEALTH AND WELLNESS

Definitions of health exist relative to a historical time frame and an ideology or dominant system in place at any given time; however, wellness is a state of physical being that is important and aspirational to most (Fabrega, 1997; Larson, 1991). For many health or wellness is perceived differently and derived from different sources. This may be due to culture, family, religion or to personal beliefs (Larson, 1991). For some, wellness is based on the medical model which alludes to being free from disease and disability; whereas, for others it may imply holism and include a balance of emotional, physical, spiritual, and mental health (Hoffman, 1996; Larson, 1991; White House, 2002).

The Medical model

The widely accepted medical model based on reductionism, describes health as an absence of disease and disability (Larson, 1991; WHO, 2001; Wyngaarden and Smith, 1985). The predominant focus is placed on functioning, diseases and illness, symptoms and syndromes (Larson, 1991; WHO, 2001). Originally conceived in 1949 by L. J. Reed, the medical model measures health on a continuum between healthy function and mortality (Larson, 1991). This continuum includes measures of physiological pain, physical and psychological disability (Larson, 1991). Critics of the model discuss that disease may exist without necessarily conceding health and that poor health may prevail without disease; therefore, "*absence of disease and infirmity may be a necessary but not a sufficient condition for an individual to be*

healthy” (Larson, 1991; pg 3). WHO (2001) discusses that while the conventional model is adept at diagnosis through masterful technology and scientific discoveries and very capable at responding to acute trauma and disease; this model aimed at isolated areas of physiology fails to provide the best means to treat chronic disease conditions, as well as comprehensive care.

The World Health Organization (WHO) model

The World Health Organization defines health as *“a complete state of physical, mental and social well being and not merely the absence of disease or infirmity”* (WHO, 1999; pg 10). WHO (1999), also states that health is a cumulative state which builds during the lifetime towards the assurance of positive well being in the twilight years of life.

The Holistic Model

Health and well being from a Complementary and Alternative perspective is based on a holistic ideology. Health is not viewed as merely the presence or the absence of disease symptoms but the prevention of disease states and the positive functioning of all states of human existence (Edlin, Golanty & McCormack Brown, 2000). The principle of holism derives its roots in ancient philosophies. Aristotle is alleged to have introduced the concept of unity in all matter (Hoffman, 1996; Stumpf, 1971). In his famous works ‘Metaphysics’ he defines the principle of holism by saying “the sum is greater than all its parts” (Vallero, 2007; pg 28). The term ‘holism’ however, was pioneered by the South African philosopher, prime minister and military leader Jan Smuts in 1926, who identified holistic tendencies observable in forms of nature (Smuts, 1961). Faull (2006) and Hoffman (1996), support these theories and their application to health. Faull (2006) and Hoffman (1996) argue, that measuring parts of the self will not sufficiently convey a sum of the overall person and that as a human being the mind and body is intrinsically connected. For this reason holistic models address not only physiological processes, but take into account thoughts, behaviors, social and cultural contexts as well as the health goals of the presenting person (Hoffman, 1996). Holism in medicine has been apparent through the ages providing medical foundations and underlying premises to many traditional and complementary medical paradigms. Some of these are Aromatherapy, Acupuncture, Ayurveda,

CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being”.

Furthermore, Maori systems of healing are classified as CAM by the MACCAH, 2003. Maori models of health such as Durie’s (1998) Whare Tapa Wha, incorporates the four walls of a whare (house) to represent Taha tinana (physical well being), Taha wairua (spiritual well being), Taha hinengaro (mental well being) and Taha whanau (family well being). This metaphorically demonstrates that health and well being from a CAM perspective is not uni-dimensional but holistic.

Holistic and integrative methods of healthcare do not work with discrete domains of illness but with merging boundaries of symptomologies. Treatments are based upon the various presenting needs of the individual to attain overall homeostasis (Hoffman, 1992). CAM while holistic in approach is based upon individual needs. Each person is viewed as unique, in that although they might be afflicted with a clinically named syndrome or disorder, they each come with a personal constitution, a set of social circumstances and underlying causes to physiological and psychological illnesses contributing to the way in which they manifest their symptomologies. Individualized approaches are therefore deemed to be paramount (Hall, 1988; MACCAH, 2004; Mills & Bone, 2000; NCAM, 2007; WHO, 2002).

Complementary Alternative Medicine (CAM) Status in Aotearoa/New Zealand

CAM in Aotearoa/New Zealand is said to date back to the early nineteenth century with the establishment of the Quackery Prevention Act (1908) (Duke, 2005). This act initially recognized some forms of CAM and suggested an enquiry for regulation (Duke, 2005). At the beginning of the nineteenth century CAM practitioners were estimated at 125 in all (Duke, 2005). The MACCAH currently estimates around 10,000 CAM practitioners in Aotearoa/New Zealand (MACCAH, 2007).

In 2001 the Ministerial Advisory Committee on Complimentary and Alternative Health (MACCAH), was established to evaluate CAM practices in other Westernized countries and to make comparisons to New Zealand CAM practice (Duke, 2005). Four main areas were targeted: regulation, consumer needs, research and efficacy and

integration (Duke, 2005; MACCAH, 2003). The discussion document was presented to the Ministry of Health in 2004 (Duke, 2005; MACCAH, 2004). Currently legislation for CAM practitioners in Aotearoa/New Zealand has only been specifically applied to Chiropractors, with the Chiropractors Act 1982. However, legislations that CAM practitioners are affected by are: the Code of Health and Disability Consumers Rights, Health and Disability Commissioner Act 1994, Consumer Guarantees Act 1993, Fair Trading Act 1986, Food Act 1981, Australia New Zealand Food Standards, Medicines Act 1981, New Zealand Code of Good Manufacturing Practice for Manufacture and Distribution of Therapeutic Goods (MACCAH, 2007).

In addition to the MACCAH's (2004) recommendations, guidelines for CAM practitioners have been established by associations, such as; The New Zealand Charter of Health Practitioners Inc (NZCHP, 2007) for CAM modalities, and the New Zealand Association of Medical Herbalists (NZAMH, 2007) for medical herbalists. Medical herbalists are a body of CAM therapists who are trained in the practice of holistic healing, to facilitate restoration of homeostasis. Herbalists employ a number of modalities including herbal medicines, diet and nutrition and various mind and body techniques.

MEDICAL HERBALISM

History

Herbal medicine has been used by humankind since time immemorial (Hall, 1988; Mez-Mangold, 1971; Oumeish, 1998). Early records found in countries such as Arabia, Egypt, India and China describe herbs commonly used as healing agents (Hall, 1988; Mez-Mangold, 1971; Oumeish, 1998). Medicines, poultices, decoctions and salves have been used by herbalists throughout history (Grieve, 1973). Herbal lore held established reputation and herbalists practiced with the respect and trust of those they served (Mills & Bone, 2000). Oral tradition maintained education of the practice and the herbal tradition remained until the 17th century when botany and medicine parted with both modalities becoming more scientific (Grieve, 1973; Richmond, Stevenson & Turton, 2003). Perhaps the most influential Greek physician, botanist and pharmacologist Pedanius Dioscorides 1AD, provided the fundamental

practices and knowledge used by herbalists today (Hall, 1988; Mez-Mangold, 1971; Mills & Bone, 2000).

Dioscorides was a pioneer in the observation of traditional beliefs and scientific validation and wrote a five volume *Materia medica* for over 500 plants (Hall, 1988; Mez-Mangold, 1971; Mills & Bone, 2000). In 1655, Dioscorides' *De Materia Medica* was translated into English by John Goodyer forming the basis for modern pharmacopeias (Hall, 1988; Osbaldeston, 2007). In 1933, *De Materia Medica* was edited by R. Gunther published and printed in London and New York with the latest publication in 1968 (Hall, 1988; Osbaldeston, 2007). With changes in politics, practices of traditional medicine and healing evolved. Prior to the 17th century a herbal compendium would have included medicinal properties of the herbs, the plant lore and botanical classifications. From then on botanical books omitted plant lore and medicinal aspects of the plants (Grieve, 1973).

One of the most the most significant changes has been from original botanical substances into synthesized chemicals. In the 1930's herbs were removed from British Pharmacopeias directing people towards more orthodox pharmacological practices (Hughes, 2002). The 1968 Medicines Act however, regained reputation and provided legal protection for herbal medicine (Mills & Bone, 2000). Herbal tradition and practices continued into contemporary times with schools providing education for herbalists from a more scientific but eclectic approach, rather than traditional oral practice (Abascal & Yarnell, 2006; Hughes, 2007; Mills & Bone, 2000).

Over the past few decades the world has seen resurgence in the use of herbal medical practice (Brems et al., 2006; Cartwright & Torr, 2005; Foster & Tyler, 1999; Furnam, 2002; Mackenzie et al., 2003; Mills & Bone, 2000; MOH, 2006; Tindle et al., 2005; WHO, 2001). In our more contemporary environment, herbalism is commonly termed Phytotherapy (Mills & Bone, 2000). Modern medical herbalism is based on older European practices in which pharmacology is integrated with herbal medicine (Mills & Bone, 2000; MOH, 2006). Medical Herbalists/Phytotherapists are a subgroup of CAM practitioners who treat people for a for a myriad of presenting problems with the aim to restore homeostasis and well being through natural healing

methods (MOH, 2006; National Institute of Medical Herbalists (NIMHS), 2007; New Zealand Association of Medical Herbalists (NZAMH), 2007).

Medical Herbalists

Herbalists are trained in the practice of holistic healing, Western Herbal Medicine and health science (Australasian College of Health Sciences, 2004-2007; College of Naturopathic Medicine UK, 1998 - 2007; International College of Herbal Medicine, 2001; MOH, 2006; NZAMH, 2007; South Pacific College of Natural Therapies, 2006). Practitioners use a range of herbal extracts, tinctures, dried herbs in encapsulated forms as well as ointments and teas (Grieve, 1973; Hall, 1988; Hoffman, 1996; Mills & Bone, 2000). Medical herbalists undergo rigorous training in areas of herbal medicine, botany, nutrition, anatomy and physiology, health science, history of holistic healing and mind and body techniques, providing them with expertise to treat individuals with an integrated approach (Australasian College of Health Sciences, 2004-2007; College of Naturopathic Medicine UK, 1998 - 2007; International College of Herbal Medicine, 2001; MOH, 2006; NZAMH, 2007; South Pacific College of Natural Therapies, 2006).

Medical herbalists facilitate well - being and the prevention of ill health through the assessment and treatment of their clients with a focus on the promotion of self-healing processes for individuals (MOH, 2006; NZAMH, 2007). Medical herbalists work towards restoring homeostasis for their clients by addressing nutritional needs, formulating herbal prescriptions, facilitating life style balance and education (MOH, 2006; NIMHS, 2007; NZAMH, 2007). Various adjuncts specific to each practitioner's college of training may be incorporated (MOH, 2006). Herbalists diagnose with some typical methods of Western medical science as well as alternative methods to determine where imbalances, dysfunctions and disorders may underlie presenting problems (MOH, 2006). Diagnosis is varied with different practitioners using differential diagnosis, tongue diagnosis, pulse diagnosis, blood analysis and Iridology/iris diagnosis (Mills & Bone, 2000). A herbalist will take a case history, observing for current stresses, dietary habits and lifestyle, as well as evaluating physiological functions of the body such as sleeping patterns and eliminatory processes (MOH, 2006; NZAMH, 2007). When an overall depiction of the presenting

person is gathered, a program is co-created with the client incorporating aspects needing to be addressed to eliminate underlying causes to their presenting problems and to restore system balance (MOH, 2006; NIMHS, 2007; NZAMH, 2007). Synergistic herbal formulations are prepared into individual prescriptions and clients will take appropriate dosages over a prescribed time frame (Mills & Bone, 2000; MOH, 2006; NIMHS, 2007; NZAMH, 2007).

Herbal Medicine

Herbal medicines are generally prescribed by trained, professional medical herbalists in the form of extracts and tinctures which are produced by quality controlled phytotherapeutic medicine manufacturers (Mediherb, 2003; Ministry of Health, 2006; Phytomed, 2007; National Institute of Medical Herbalists (NIMHS), 2007; NZAMH, 2007). Medicines used by medical herbalists are labeled as 'Practitioner Only' (MOH, 2006). The medicines are combined together in individual formulations as required by individuals (Hall, 1988; Mills & Bone, 2000). Constituents within herbal medicines contribute to an extensive range of therapeutic actions on the body; therefore, classifications exist with hundreds of plant species falling under specific headings. Plants affecting overall well - being would be classified as follows;

Adaptogens - plant constituents that assist to increase the body's resistance to trauma or stress

Astragalus - *Astragalus membranaceus*

Panax Ginseng - *Panax quinquefolius*

Siberian Ginseng – *Eleutherococcus senticosus*

Withania - *Withania somnifera*

Nervines - tonifying elements for nervous system restoration and energy balance

Chamomile - *Matricaria Chamomile*

Hops - *Humulus lupulus*

Kava - *Piper methysticum*

Lemon Balm - *Melissa officianalis*

Oatstraw - *Avena sativa*

Passion Flower - *Passiflora Incarnata*

Skullcap - *Scutellaria lateriflora*

St John's Wort - *Hypericum Perforatum*

Valerian - *Valeriana officianalis*

Vervain - *verbena officinalis*

Tonics - increase vigor and feelings of well being

Alfalfa - *Medicago sativa*

Dandelion Root - *Taraxacum officinale*

Echinacea - *Echinacea Angustifolia or Pupurea*

Fenugreek - *Trigonella foenum-graecum*

Hawthorn - *Crataegus*

Licorice - *Glycyrrhiza glabra*

Lavender – *Lavandula officianalis*

Nettle - *Urtica dioica*

Oatstraw - *Avena sativa*

Panax Ginseng - *Panax quinquefolius*

St Mary's Thistle - *Silybum marianum*.

Other therapeutic actions are more physiologically based, such as: alteratives, analgesics, diaphoretics, diuretics, expectorants, hepatics, laxatives, lymphatic tonics and stimulants (Hoffman, 1996; Mills & Bone, 2000). Hundreds of plant extracts and tinctures fall into these categories (Grieve, 1973; Hall, 1988; Hoffman, 1996; Mills & Bone, 2000). Over 4000 clinical trials have been conducted on various herbal medicines with mixed results; however, limited empirical support has been established for efficacy (MACCAH) 2003; Kune & Kune, 2005; MacLennan et al., 1996). Clinical trials on herbal medicines are currently increasing due to the demand for empiricism within the herbal world (MACCAH, 2003; Mills & Bone, 2000). Of all the herbal medicines perhaps the most subjected to clinical trials is that of St John's Wort - *Hypericum Perforatum*, which is often used for symptoms of low mood.

St John's Wort - *Hypericum perforatum*

Much controversy has surrounded this herb and its use for depression. St John's Wort - *Hypericum Perforatum* has been subjected to clinical trials since the eighties, some proving to be useful and some questionable (Abscall & Yarnell, 2001; Linde et al., 2006; Pilkington, et al., 2006). The New Zealand Guidelines Group as contracted by the New Zealand Ministry of Health, conducted a review of the evidence for clinical studies into St John's Wort and is available on the New Zealand Guidelines Group CAM homepage (cam.org.nz, 2006). The Graphic Appraisal Tool for Epidemiology (GATE) criteria (<http://www.health.Auckland.ac.nz/populationhealth/epidemiology/biostsa/epiq/>) was used to evaluate the studies and the findings portrayed positive relief for low mood or mild depressive symptoms (cam.org.nz, 2006). Many clinical trials on St John's Wort report positive results for low mood or mild depressive symptoms (Abascal & Yarnell, 2001; cam.org.nz, 2006; Francis, 2005; Linde et al, 2006; Pilkington et al, 2006; Rasmaussen, 2002; Zuess, 2003). A meta analysis conducted by Linde et al (2006) across 37 trials of St John's Wort globally discussed the heterogeneity of efficacy. St John's Wort improved symptoms when compared to placebo and produced results similar to antidepressants for mild to moderate depression (Linde et al, 2006). Benefits were minimal when compared with placebo for severe depression.

St John's Wort contains active constituents of Hypericin and hyperforin which appear to increase levels of norepinephrine, serotonin and dopamine (cam.org.nz, 2006; Pilkington, et al., 2006; Rasmaussen, 2002; Zuess, 2003). Studies report that St John's Wort extracts appear to cause fewer negative side effects than tricyclics but similar side effects to SSRI-s (cam.org.nz, 2006; Linde et al., 2006). It is imperative to consider when administering or taking St John's Wort that this herb is contraindicated with other medications due to interaction effects (cam.org.nz, 2006; Pilkington et al, 2006; Rasmussen, 2004; Zuess, 2003). Due to the affect on the cytochrome P450 enzyme system, the metabolism of other pharmaceutical drugs is increased, reducing plasma levels and the effectiveness of other medications (MOH, 2006; Pilkington et al, 2006; Rasmaussen, 2004). Other nervines are often chosen for those experiencing depression for this reason (Rasmaussen, 2002). Some herbs that are helpful with elevating low mood and reducing tension are, extracts of: Brahmi -

Bacopa monniera, Californian Poppy -*Eschscholtzia californica*, Kava – *Piper methysticum*, Lemon Balm - *Melissa Officinalis*; Oatstraw - *Avena Sativa*, Panax Ginseng and Valerian *Valeriana officinalis* (Abascal & Yarnell, 2001; Rasmaussen, 2002). Although herbal medicines are predominantly used by herbalists for symptoms of low mood/ depression; other therapeutic supplements are very often implemented as well.

Adjunct medicines

Zuess (2003) explored the holistic approach to depression and discusses in his article the benefits of this all round form of therapy. Zuess (2003) emphasizes physiological conditions that may contribute to symptoms of low mood. For this reason he advocates that therapists administer rigorous screening for a number of possible contributory conditions, such as: allergies, sugar malabsorption, endocrine imbalance, depressed immune response, bacterium such as *Helicobacter-pylori*, nutritional deficiencies and toxicity levels. Alongside a number of other CAM researchers, he also advocates for an integrated approach with herbal medicines and supplements (Abascal & Yarnell, 2001; Pilkington et al., 2006; Zuess, 2003).

Omega - 3 fatty acid supplements are recommended by CAM practitioners for depression in the form of fish oils or flaxseed oils (Abascal & Yarnell, 2001; Pilkington, et al., 2006; Zuess, 2003), Omega – 3 fatty acids are found to be deficient in individuals experiencing depressive symptoms and have been identified as a possible contributory factor to some individuals experiencing mood disorders (Parker, Gibson, Brotchie & Heruc, 2006). Folate and vitamin B complex supplements are often recommended alongside herbal medicines, to address the nervous system (Pilkington et al, 2006). Pilkington et al, (2006) and Zuess (2003) also discuss the benefits of taking amino acids such as 5-hydroxy-tryptophan/5-HTP, a naturally occurring amino acid and precursor to serotonin levels and S-adenosyl – methionine/SAM-e, which promotes neuronal membrane viscosity influencing 5-HT metabolism. SAM-e is also a glutathione precursor (Pilkington et al, 2006; Zuess, 2003). Although a combination of herbal medicines and supplements may contribute to perceived enhancement of low mood; combinations of some pharmaceutical medicines such as oral contraceptives and benzodiazepines and herbal medicines such

as St John's Wort - *Hypericum perforatum* and Kava - *Piper methysticum* are contraindicated (Thompsons, 2007). If used incorrectly the holistic approach can contribute to potentially high risk factors (Mills & Bone, 2000; MOH, 2005; Thompsons, 2007).

Risk Factors

While there is potential for risk with CAM; many perceive herbal medicines to be safe because they are natural. This is a misnomer and risk factors of CAM are increased when inexperienced consumers self medicate or if practitioners are not vigilant and administer herbal medicines with either a low therapeutic margin or high toxicity (Barnes, Mills, Abbot, Willoughby & Ernst, 1998; MOH, 2006; WHO, 2002). The Ministry of Health (2006) suggest as risk factors for CAM, a lack of knowledge about CAM from medical professionals when clients express that they use or have preferences for CAM. As well, clients who neglect to discuss their CAM use with their medical professionals may potentiate adverse interactions between pharmaceutical and botanical medicines (MOH, 2005). Tindle et al., (2005) ascertained that 60% of CAM consumers in the USA do not discuss their CAM use with their GP's as they regard it not to be important to the doctor.

A survey reported in the Waikato Hospital emergency department found that 38% of presenting individuals used CAM and that 57% of the sample did not discuss this with their doctors (MOH, 2005; Nicholson, 2006). On the other hand, Kune & Kune call attention to the relatively marginal risk with CAM treatments as opposed to a number of orthodox treatments. They further add that the risk they perceive as notable with CAM treatments is when orthodox treatments are withheld in favour of CAM treatments, when a critical condition prevails that may respond to orthodox treatment (Kune & Kune (2004). It is acknowledged by the MACCAH (2003), for safety and efficacy further research into CAM is essential.

Complementary Alternative Medicine research and development

Critique of CAM is regularly based on an evident dearth of empirical validation (Kune & Kune, 2005; MacLennan et al., 1996; MOH, 2006). Kune & Kune (2005) discuss that many CAM practitioners are vehemently confident in their longitudinal, anecdotal

and traditional evidence; thereby, lack the incentive to conduct empirically based research. Furthermore, Kune & Kune (2005) discuss that mainstream orthodox practitioners often tend to be fervent with criticism of CAM, particularly when comparing evidence based medicine with alternative medicines. Kune & Kune (2005) suggest the apparent credibility of the scientific model may contribute to prejudice against CAM. However, Furnam (2002) and MACCAH (2003) discuss that a scientific model is not deemed as entirely appropriate for CAM.

CAM practitioners apply individualized therapies covering any number of aspects such as diet, medicine, relaxation techniques and lifestyle changes and randomized controlled trials tend to lack the inclusion of such individualization of treatments within their designs (Furnam, 2002; Kune & Kune, 2005; Pilkington, et al., 2006). As CAM is based on alternative models of health, testing within a standard biomedical model does not necessarily constitute an effective approach to determine CAM efficacy (Furnam, 2002; MACCAH, 2003). To the contrary, Ernst (2000) argues that Cam research is unsuccessful in appealing to experienced researchers due to the absence of a sound research methodology or infrastructure. As well, funding for CAM research is reported as scarce making for difficulty in conducting empirical research (Ernst, 2000; Kune & Kune, 2005; MACCAH, 2003; Saks, 2005). Increasing the evidence base for CAM is an area that is currently being addressed with discussion documents being provided and updated by organizations such as the Ministerial Advisory Committee on Complimentary and Alternative Health (2004) and the World Health Organization (2001; 2002). Discussion exists as to what may constitute appropriate research methods for CAM (Cartwright & Torr, 2005; Furnam, 2002; Kune & Kune, 2005; MACCAH, 2004; Saks, 2005). The MACCAH (2003), have suggested a CAM methodology should include both qualitative and quantitative methods. This may enable participants' perceptions of treatments to be compared to actual results in their health and well being thereby ascertaining what it is about the treatment that works for them. Despite a deficit in empirical evidence for CAM, studies conducted portray perceived efficacy and satisfaction of consumers, as well as people's preferences for CAM (Furnam, 2002; Fox, 2005; Kune & Kune, 2005; Lewith et al., 2006; MACCAH, 2004; MOH, 2006; WHO, 2001).

Research to date into CAM has identified similar reasons for people's choices for this form of healing (Astin, 1998; Brems et al, 2006; Furnam, 2002; Garrow & Egede, 2006; Kune & Kune, 2005; MacLennan et al., 1996; Tindle et al, 2005). Reasons provided by authors for patients choices for CAM have reflected 'push' factors such as concern about negative side affects of medications or ineffective treatments and 'pull' factors reflecting influences of the media or family and friends, positive effects of herbal medicines, length of the consultations, autonomy with health decisions, congruence with beliefs and values, treatment meaning and cultural perspectives (Astin, 1998; Cartwright & Torr, 2005; Furnam, 2002).

While these reasons for choices for CAM therapies are productive and fruitful for insight into the population of CAM consumers, little is mentioned about individuals' perceptions of what they perceive to be efficacious, or their experiences of the treatments (Cartwright & Torr, 2005). In part this may be accounted for by the research methods used with CAM. As an effective methodology for CAM inclusive of qualitative and quantitative methods has been suggested but not yet established, predominantly top-down research methods have been employed which do not account for patients perspectives (Cartwright & Torr, 2005; MACCAH, 2003). It has been recognized however, that clinical and value driven research methodologies into the CAM treatments from consumer's perspectives' is needed as popularity for this modality increases (Cartwright & Torr, 2005).

Therefore, researchers Cartwright & Torr, (2005) engaged in a qualitative research project to explore the experiences of CAM users. They recruited 11 participants (10 female) aged between 23 and 66 years who had visited six different modalities of CAM and conducted in depth interviews with them, analyzed the interviews, then observed for emergent correlating themes. Results showed that while the modalities visited were varied, i.e., aromatherapy, acupuncture, homeopathy and reflexology; similar perceptions were held about the treatments demonstrating the holistic approach as pivotal (Cartwright & Torr, 2005). Various elements of the holistic approach were regarded by participants as beneficial. Education was seen to be a significant theme (Cartwright & Torr, 2005). Participants reported explanations provided by practitioners linking psychological and physiological elements of health

and ill-health to be helpful, as they revealed reasons for imbalance and promoted understanding. This in turn was suggested to have fostered better understanding of wellness therefore encouraged patient autonomy over personal health care, which was perceived to be positive (Cartwright & Torr, 2005).

Furthermore, perceptions held by participants largely reflected the importance of the patient - practitioner relationship. The therapeutic relationship was considered as paramount, to all participants. It was discussed that the egalitarian relationship between the practitioners and the participants encouraged pro - active participation in decision making, with regard to personal health issues (Cartwright & Torr, 2005). As well, the bi-directional relationships encouraged trust, therefore disclosure, and in turn more individualized treatments (Cartwright & Torr, 2005). Due to a sense of support perceived by the participants, they felt more able to cope with their illnesses as well as other life stressors (Cartwright & Torr, 2005). The client-practitioner relationship was reported to be facilitative to the ease of personal application of health care and contributed to lasting effects of the treatments (Cartwright & Torr, 2005).

In addition to the therapeutic relationship, the psycho-therapeutic qualities administered, were described by participants to reduce anxiety and enhance feelings of personal acceptance. Counseling and psycho-therapy were perceived as salient to efficacy (Cartwright & Torr, 2005). Effects of treatments noted by participants went beyond symptom relief and were reported to enhance relaxation and energy levels, restore balance, and encourage self reflection and coping skills (Cartwright & Torr, 2005). These effects extended to long term effects; in that, the participants thought they were more able to prevent negative health states and to maintain feelings of well being through learned adaptive coping skills (Cartwright & Torr, 2005).

The participants in Cartwright & Torr's (2005) study sought Complementary Alternative therapies and were described as being smart consumers. This meant that while they were concerned about side effects of pharmaceutical medications and wanted CAM; they also questioned the efficacy of CAM, sought anecdotal evidence and observed for personal physiological change (Cartwright & Torr, 2005). Initially

the participants reflected medical pluralism as they continued with orthodox medicine alongside their CAM therapies. Over the time they engaged in CAM therapies; however, visits to G.P's became less frequent. This was said to be partly reflective of increasing doubt with the orthodox approach and an increased level of personal health care (Cartwright & Torr, 2005). Participants in this study supported previous research into initial choices for visiting CAM practitioners by exhibiting factors, such as, concern about side effects of medications, dissatisfaction with past orthodox treatment and wanting a holistic approach (Cartwright & Torr, 2005). Although CAM consumerism, as well as CAM research is increasing, it is still apparent that there is a dearth in the evidence base.

Research Questions

As CAM use continues to increase, research questions remain outstanding as to whether these systems work, why they work and what is it about CAM that works (Cartwright & Torr, 2005; Furnham, 2002; Kirmayer, 2004; Saks, 2005). In many cases consumer preference is evident for CAM with low mood/depression (Rascoe et al., 2004; Wu et al., 2007). However, questions remain with regard to the appropriateness and efficacy of this form of therapy, given the safety issues surrounding severe depression and also around herb – drug interactions (Pilkington et al, 2006; Saks, 2005). I was interested to see if people in Aotearoa/ New Zealand frequent CAM therapists for low mood/ depression and decided to embark on a qualitative research project into perceptions New Zealanders may hold about herbalists' treatments for depression.

This thesis; therefore, represents my exploration of people in Aotearoa/New Zealand who have visited CAM practitioners - specifically Medical Herbalists, for treatment of low mood and depression and how they their perceived treatments to be. I was particularly interested in peoples' perceptions about these treatments. Why were they seeking this alternative form of treatment and how did they respond to it? What did they think about the therapeutic relationship? What was it about their treatments that they perceived as helpful and what was not? How did the treatments impact on low mood and were the effects of these treatments lasting? Were there any barriers to accessing CAM treatments? As many medical herbalist's treat their clients with multi-

faceted approaches, I was also interested to see whether one particular dimension of this system was particularly relevant to healing or whether effects were possibly due to the integrated approaches mentioned by researchers. As well, I was curious to know whether the participants would hold similar perceptions about the treatments to each other.

CHAPTER TWO: METHOD

Methodological Considerations

This study involved a qualitative research process. Data was collected by way of semi-structured interviews which were followed by transcription of the interviews followed by the reconstruction of case studies. A cross case analysis was undertaken observing for themes pertinent to the subject matter and the literature. This is a method appropriate for qualitative research originating in the 1980's and 90's which involves participants discussing their experiences with the researcher (Flick, 2006). It is accepted that participants have personal proficiency about the subject matter through personal experiences, to be accessed and reconstructed (Flick, 2006). Flick (2006) reports both advantages and disadvantages to this methodology as presented below.

Advantages

A semi-structured interview encourages the subjective viewpoints of the participant through open ended questions while still allowing for some hypothesis directed questions and some confrontational questions. A semi-structured interview can progressively develop with suggestions by the researcher to assist in eliciting the implicit knowledge of the participant.

Disadvantages

Interviews may possibly lack structure thereby participants may digress from the subject matter. As well, interpretation may be problematic due to the subjectivity of both the researcher and the participants. This methodology therefore requires appropriate adaptation to the subject matter and the participants, and careful execution.

The Researcher

As a Clinical Psychology student, in accordance with the NZPsP Code of Ethics and a personal belief that research can never be completely free of bias, I believe it is important that I explicate my perspectives, perceptions and influencing factors to the research topic.

I am a Celtic New Zealand woman in my early 40's. My husband also hails from Celtic genealogy and we have two teenage daughters. As a young person I was always eager to study Psychology and when I entered my mid thirties the opportunity arose. Furthermore I have had a long time interest in herbal medicines, the ways of my ancestors, and the healing practices of indigenous peoples. In my mid twenties I undertook a Diploma in Herbal Medicine and practiced clinically for fourteen years. During this time it became apparent to me that the holistic model of health, that we are the sum of our interconnecting parts (Faull; 2006; Hoffman, 1996), is a sensible perspective. It became equally apparent that when the person is viewed as whole and treated as such, amazing healing can occur. This perspective is in complete opposition to reductionist theories in which a person is reduced to isolated parts. These parts are addressed and treated with overlook to the other dimensions of a person's life often contributing to a state of un-wellness (Descartes, 1968; Mills & Bone, 2000). While in Undergraduate and Honours studies I often thought about how the holistic approach might be studied from a Psychological perspective. Doing a Masters thesis has provided me with the opportunity to do so. That many clients would present to me with low mood, provided me with the notion to explore people's experiences and perceptions of treatments by Medical Herbalists for low mood.

I would like to add that although I perceive holistic methods to be efficacious and safe for many afflictions when practiced by qualified practitioners; I also regard the medical world as holding an important role in the well being of society and for myself and family both methodologies are utilized as required. Furthermore, my preferences are for pluralistic health methods in which orthodox Western medicine and Complementary Alternative Medicines co-exist and work harmoniously with each other. I do believe that the approach of the practitioner in any field is important to a person's feelings of well being, empowerment and recovery and I believe that in many cases people know what methods are right for them. It is my wish however to see a system in New Zealand which acknowledges, accepts and incorporates alternative methods into the health care system in much the same way that Australia and Britain does, making alternative health care more accessible to consumers and more viable for practitioners.

Interview Outline

The interviews were designed from a qualitative, open ended but semi-structured perspective based on themes hypothesized from the literature (Bone, 2001; Francis, 2005; Furnham, 2002; Kirmayer, 2004; Linde, Mulrow, Berner & Egger, 2005; Saks, 2005; Xu, Luo & Tan, 2004; Yarnell & Abascal, 2001). The semi-structured interview allowed opportunity for participants to openly discuss their stories and articulate their personal meanings. Flick (2006), reports semi-structured interviews to be appropriate when researching participants' subjective theories as it allows for their implicit knowledge to emerge spontaneously. Bergen (1993) as cited in Flaherty (1996), refers to semi structured interviews being appropriate for researching sensitive topics. I considered this research topic to be sensitive in nature therefore suitable for a qualitative research methodology. In some interviews emotions were elicited that were associated with participants' past experiences of low mood. The interviews followed a general format covering subject areas as described below (to see the interview outline refer to appendix 1).

1. This section included the participant's age, gender, culture, occupation, where they were from and relationship status and children. It included confidentiality, confirmation of understanding what the research was to be used for, an over-view of the interview procedure and signing of the consent forms.

2. This section covered the participant's history of depression/low mood experiences. It included symptomology and previous treatments including orthodox and complementary medicine.

3. This section was to discover why participants had initially sought treatment from a medical herbalist and their reasons for their choice in this type of health care. Factors included the possibility of influences from culture, family, spirituality, past experiences with orthodox or alternative complementary practitioners, media and friends.

4. Section four covered the consultation and treatment processes that participants had engaged in. It included the treatment period, lengths of consultations, medicines,

diets, herbal teas, vitamins and supplements, education of the presenting disorder or condition, counseling and lifestyle guidance, techniques taught, exercise regimes, ease of treatment programs and compliance and referrals to other practitioners.

5. This section was intended for discussion of treatment effects. Whether the treatment had positive, negative or neutral effects was encompassed, as well as what participants perceived to be contributing facets to the results they did or did not experience. Factors suggested if not already contributed by participants incorporated areas of consultation processes, personal control, responsibility and power equities, beliefs, confidence levels, holistic paradigms, support of others, changes in function and energy levels, psychological factors and financial perspectives.

6. Future Implications were discussed in section six. This section was to gain insight into impressions that participants had formed as a consequence of their treatments by herbalists and to ascertain whether the treatments engaged in were considered valid for future utilization for themselves or for recommendation to others. Whether or not a person may or may not return to a herbal practitioner as opposed to buying over the counter products was also explored. Participants were given the opportunity to express any perceived barriers they thought may be present when accessing the services of a herbalist in New Zealand.

7. Closure of the interview. Participants were given the opportunity to add anything they wished to their stories. This brought forth different personal perspectives that people felt were meaningful to the research, enriched dimensions already included and in some cases introduced new ones. Participants were then asked if they had any further questions about the interview or the research then debriefed. Participants were offered the opportunity to read their transcripts or the thesis. Autonomy for participants to contact me at any stage of the study with regard to discussion of any aspect of the research was reiterated.

8. The interview guide, the information sheet and the poster accompanied an application form which was submitted for ethical approval.

Ethical Approval

Ethical approval was initially applied for and granted by the University of Waikato Psychology Research and Ethics Committee. Key to ensuring the safety of participants was the provision of accurate information of the use of the research. This occurred both verbally and through the information sheet provided, by guaranteeing participant anonymity through pseudonyms and with the absence of any identifying information within the thesis. It was made clear that participants had full autonomy to withdraw from the research at any time, if they chose to. As well, debriefing was planned for after the interviews to ensure that clients were not feeling traumatized by the reactivation of past traumatic events.

Recruitment of participants

Following ethical approval, participants were sought. I aimed to engage the participation of a diverse sample of genders, ages and cultures and employed various methods to access respondents. Firstly, I designed a poster accompanied by an information sheet to advertise the project (see appendix 2a & 2b). These were displayed in alternative health retail shops. The posters and information sheets were also displayed at the University of Waikato's Psychology department and the Waikato Institute of Technology's Health and Nursing departments. An editorial was printed in the newsletter of the New Zealand Association of Medical Herbalists and editorials were printed in the Waikato Times and the Hamilton Press. As well, the article in the Waikato Times was placed on the Scoop media website. Several Waikato and Auckland based herbalists were phoned, emailed and mailed posters and information sheets to display in their clinics, if they consented. Alternatively, it was suggested that they may approach clients they had treated for low mood and pass the research information on to them. I approached two clients I had treated in the past for low mood who had previously shown interest in participating in the research. I was also given the opportunity to speak about the research to a national Phytotherapy conference with regard to recruiting participants. Respondents were screened for the criteria of 'treatments by herbalists' as many responded to the advertising, however most were self treated with retail health products. Criteria included that participants must have been to visit a medical herbalist and received treatment for low mood or depression.

Demographics of Participants

I began the research and initially encountered difficulty in obtaining participants with such a narrow criteria. As only 4% of New Zealanders are recorded as using Complementary Alternative Medicines and only 1.8% utilize Medical Herbalists with unreported statistics for those presenting with low mood or depression, I encountered a very limited target population (Ministry of Health (MOH), 2004). The random participant sample engaging in this research comprised six women aged between 29 and 51. Five of the women identified as Pakeha and one as Maori. Three of the women were professionals, two were students and one was a home executive. With relation to domestic status at the time, two of the women were married with children, while one was in a de facto relationship with children. Three of the women were single mothers and all were urban dwellers. All had been to medical herbalists and received treatments for symptoms of low mood. As this was only a small sample it eventuated that four of the participants had been to two herbalists. Dana and Siobhan had seen the same practitioner, as with Jan and Lisa. In all the six women visited a total of four practitioners between them.

Table 1. Demographics of participants		Participants	%
Age	29 – 51		
Gender	Female	6	100
Culture and Ethnicity	<i>Pakeha</i>	5	83
	<i>Maori</i>	1	17
Occupation	<i>Professional</i>	3	50
	<i>Student</i>	2	33
	<i>Home Executive</i>	1	17
Family status	<i>Married with children</i>	2	33
	<i>Partnered with children</i>	1	17
	<i>Single with children</i>	3	50

Interviews

Respondents were given an information sheet prior to the interview and understanding of the project was confirmed by them. Participants were offered a choice of location for the interview. Three interviews took place in my work office. Two were conducted in the participants' homes and one interview was conducted by

phone to a participant residing in the South Island. Ethical issues were discussed such as confidentiality and participants rights to withdraw from the study at any time should they choose to. Participants were informed that could discuss aspects of the research at any time by contacting me at my expense. Opportunity for participants to read personal transcripts, as well as the thesis on completion, was also offered. Consent was signed by the participants at the end of receiving all appropriate information and prior to commencing the interviews. As well, consent was also obtained from participants to access personal medications from their practitioners if they were unsure of what they had been taking.

All participants were interviewed about their experiences of treatments under the care of medical herbalists while they were experiencing low mood. The same interview outline was used in all interviews. The questions generally followed the interview outline; however, were not constrained by the structure and the interviews progressed according to the interviewees responses. All questions in the interview schedule were covered at some stage if information had not been volunteered the first. Interviews were audio taped and typed them into my lap top computer in brief, by myself. The telephone interview was conducted over the phone's speaker system, audio taped and typed. On completion of the interview a debriefing followed to ensure that no reactivation of trauma had occurred after the disclosure of sensitive information within the interview. Fortunately this did not transpire as participants either felt fine or felt that the opportunity to be able to share their experience was positive for them. The interviews varied in length with the shortest taking one hour and the longest taking two hours and twenty minutes

Case study construction

1. The interviews were transcribed in full on an Express Scribe computer program (<http://www.nch.com.au/scribe/>) and double checked against the computer typed notes if required.
2. Transcripts were read back while replaying the recorded interviews to check for accuracy.

3. Main themes were then identified in accordance with the literature and the interview outline to be observed for within the transcripts. These included demographics, choices for treatments by herbalists, depression factors, consultations, perceived efficacy, practitioner's approach, objectionable aspects of treatment, perceived benefits to symptomology and future implications.
4. Case studies were constructed in accordance with the themes. Pseudonyms were assigned to all participants to preserve anonymity.
5. Individual transcripts and case studies were coded into hypothesized and emergent themes and put into tables in accordance to coding (refer to tables 1 – 10).
6. Each participant was considered as an individual case for analysis and comparison to the other cases while similar themes occurring for participants became apparent.

Cross case Analysis

1. As well as case study construction, further data analysis took place across the tables. The tables 11 – 20 may be seen in pages 109 -118.
2. Emergent themes or were identified through summaries of the tables 1 - 10 which are included in the discussion section.

CHAPTER THREE: CASE STUDIES

Case Study One: Dana

Dana is a Pakeha woman of thirty three years. She is professional analyst who is also a sole parent to her son. Dana experienced a surprise pregnancy in her early twenties. She split up with the father of the baby early in the pregnancy and was not upset about the relationship ending. She felt it was not a relationship that was going anywhere therefore there was not a lot of grieving to be had over it finishing. Part way through her pregnancy Dana moved into her parent's home who were totally supportive, excited about the baby, and non - judgmental of Dana's single motherhood. Dana remained at her parent's home for some years to come. After Dana's baby was born and was between six – nine months old, Dana began to experience depression. This was not an entirely new phenomenon for her as she recalled having bouts of it as a teenager although she had not ever been treated for it. This time however, Dana recalled becoming emotionally low with being a new single mother. At the time she was experiencing reduced energy levels to the point of total exhaustion and was crying a lot. She had lost all libido and described having 'a flat voice' which she had experienced with depression before. Dana described her condition as "post-natal" depression although she did not realize this at the time.

It was probably when Mark was about six or eight months maybe even nine months old and things were just really horrible, really not coping, not wanting to get out of bed, feeling really numb. I felt like this was not the life that I wanted. I didn't have any friends having come from university and having friends who were busy studying, and I hadn't found any friends who understood what I was going through. It was definitely post-natal. It was sort of feeling like I'd been dealt a life which of course I'd chosen you know, but I just saw that there was no possibility in it really, and that this was how it was going to be for ever. And I think that's one of the hardest things about depression. Feeling like you're going to be stuck there forever.

Dana's very supportive family began to recognize that Dana was struggling. Dana was unaware that she may have been depressed but discussing her feelings with her mother and sister brought the situation to light. Dana's mother had become a health care worker when Dana was a teenager and along with this vocation brought for her mother an interest in natural therapies. Her mother's interest also brought about an increased awareness for Dana of alternative methods, although she says she really adopted them for herself when she came into her twenties and even more so after the arrival of her baby. Dana's mother suggested perhaps if she visited a medical herbalist she might be able to get some help and offered to pay for a consultation for her. Dana decided to take up the opportunity as she wanted to get some help but was not keen to try anti-depressant medications.

I was wanting to do something that wasn't going to screw my head up even more and mum had had a lot of success with using herbs and I think my sister might have been starting to get into it as well. So yeah, the family didn't push me into it by any stretch of the imagination, it was just I saw that this was a really good idea and I was really desperate and Mum basically said "look this will work". So I was desperate but not desperate enough to try drugs.

Dana made an appointment to see a local herbalist and engaged in one consultation with her. At the time Dana was feeling very low and desperate and when asked by the herbalist what was happening for her, Dana burst into tears and told her that she 'felt sad all of the time and didn't want to be here'. The herbalist offered a very minimal reaction. Dana recalled her pushing a box of tissues across the floor and offering no compassion as a response to her emotional expression which she found quite disconcerting. She felt at the time she needed to hear something reassuring or to experience some emotional engagement, however, this was not forthcoming. For Dana it was important that the herbalist showed that she cared and she felt shaken that the herbalist offered nothing.

So off I went and saw the herbalist and I burst into tears in the consultation and she didn't really do much about that at all, which I

thought was pretty on the nose. She didn't sort of say 'are you ok?' or didn't say 'oh you know I can see you're really upset'. There was just sort of no sympathy or empathy or emotional engagement what-so-ever which at the time was just what I needed, I really needed to hear that. I think that's very important in a herbalist you know or in any practitioner that they show that they care you know. Yeah, especially when somebody comes to you with their bloody guts on the floor. I mean we're talking human stuff here, like when someone cries in front of you, you say something soothing you know. You say 'hey take as much time as you need, or do you need a tissue, or I can see it's really hard for you', something like that. She just grabbed a box of tissues and put them on the ground. I just sort of thought, well I was really, really, desperate at the time and to have someone just show nothing..., well then I felt really embarrassed that I'd cried, it was not good. But I got through that and she prescribed me a formula which I think by memory had hypericum, withania, passionflower and something else in it.

Dana remembered during the consultation being asked about her baby's birth which had been a good homebirth and she was also queried about her diet. She was not offered any information about what she may be experiencing, such as post natal depression or even depression. Dana was prescribed herbal medicines which she commenced following her consultation and was recommended to take Floradix (an iron and vitamin liquid tonic). Dana's herbalist had not encouraged a second consultation nor referred her on to another health professional such as a psychologist or a mental health professional but rather said to Dana to let her know when she needed another bottle of medicine. Dana took her medicines twice daily for a period of approximately six months and perceived them to work well for her. She did not experience any compliance issues despite finding the taste disgusting. She described her herbal medicines as "uplifting"; however, she was not inclined to return back for a second consultation due to being so unimpressed by the herbalist's manner.

Around the same time that Dana went to the herbalist she also engaged in a self development course and private counseling. Dana spoke about the various aspects

contributing to her recovery such as her supportive family, the self development course and the counseling, however when queried on her thoughts about the key factor in her healing process Dana spoke about the herbal medicines.

I think it was the herbs actually. Yeah, I remember feeling at the time after about three days things were quite different and that's why I think they're very powerful things. And I don't know whether that's a placebo thing or a proven medical thing. I don't really give a damn, it worked you know and it didn't bend my mind or anything and it was reasonably cheap so as far as I'm concerned it's a really good thing.

Although Dana had not perceived her practitioner's approach as ideal she did recall feeling different after her treatment session. She thought that taking an action towards helping herself get better felt contributed to this change in affect. Dana very soon began to feel "lighter and brighter" and her energy levels increased. Dana began to feel like her old self again. A few years later Dana was experiencing symptoms of low mood again. In the interim between her last episode of depression and the current episode, one of Dana's family member's had become trained as a medical herbalist. With this later episode of low mood, Dana decided to return to natural therapy but thought this time she would visit her family member as a client. She recalled this to be a very positive and helpful experience. Dana emphasized that although this was a family member, she was treated in a very professional manner and that the family dynamic did not feature in their therapeutic relationship.

With this later treatment Dana was also prescribed herbal medicines. This time she was taking St John's Wort – *Hypericum perforatum*, Withania - *Withania somnifera*, Licorice – *Glycyrrhiza glabra* and St Mary's Thistle – *Silybum marianum*. In addition to these medicines, Dana also took Bach flowers of Aspen - *Populus tremula*, Beech - *Fagus sylvatica*, Gentian - *Gentiana amarella*, Walnut – *Juglans regia*, White Chestnut – *Aesculus hippocastanum* and Wild Oat - *Bromus ramosus*. Although Dana recommenced prescribed herbal medicines, other aspects to her low mood were also addressed. The herbalist spoke about eating well, herbal teas, exercise and counseling. As well, she spoke to Dana about the importance of getting help for her depression.

Yeah she certainly talked about the other stuff that you need to do around exercise and eating well and at one point she recommended counseling. She was a lot more holistic in her approach, like she said 'hey the herbs are really good but you also need to do this other stuff, like be responsible about the emotional stuff. The issues that you are talking about, you need to get some help for some of those.

Dana visited this herbalist two - three times and made comparisons between the two herbalist's approaches. She recalled feeling disempowered by the first herbalist but the second herbalist explained things throughout the consultations, answered questions and would refer to books if she needed to. Dana found this reassuring and saw it as a good sign that this herbalist cared enough to double check when necessary. Although Dana recalled everything about her second herbalist's treatment as helpful, she also felt empathy from her, which was the critical facet she deemed to be missing from her first experience.

I think that she was certainly a lot more empathetic and actually emotionally present. I know that with other clients she's had that's been something they've really commented on. That they've felt really listened to and she is very much like that as a person you know, just quietly accepting of what people are going through and not shocked by anything, just makes some gentle suggestions sort of thing which I think is really important as a herbalist. Better bedside manner.

These days, Dana manages her occasional reoccurring depression with the strategies she learnt from the self development course, over the counter St John's Wort extract or tincture, and an occasional informal chat with her family member herbalist. She discussed the use of herbalists for others. Dana thought that if someone was to query her about her depression she would refer them to a herbalist first before a general practitioner as she experienced "great success". She particularly liked the long consultations believing this to give herbalists a clearer perspective of the client's life. Dana uses a homeopath for her son and described this practitioner as 'a very empathetic, respectful and non-judgmental guy' who has always respected Dana's

knowledge as a mother. The treatments prove to be efficacious for him. Dana had thoughts about herbalists not being taken seriously by a large part of the population. She described the herbalist's stereotype as 'tree – hugging, crystal - loving hippies' to be possibly off putting and how herbalists need to improve their research and knowledge base as well as their bedside manner, to gain more confidence from people. Dana considered it ironic that the orthodox medical model appears to have more authority over people as she considered this model to only address part of a person's state of ill-health.

Yeah it's that stuff of not really acknowledging that people are more than their symptoms and I think that a lot of people don't really want to take responsibility for their own health and they're quite prepared to go along with that power. Just go along and Doctor knows best and get some pills and perhaps not do a lot to find out why or what it is that's going on. If you think like I do, that your emotions manifest in your body in some pretty wacky ways, for the most part that's what's going on with people. I think the medical/scientific model doesn't make a lot of space for that, that's a real plus about herbal, that there's an acknowledgement that their (people's) emotions are a key part of it really.

Dana perceived the main barriers to people accessing the services of medical herbalists to be not just the stereotyped attitudes of people towards herbalists, but also that medical herbalists are not part of a subsidized health care system. At one point Dana was provided with a sickness benefit to access alternative therapies while she was on the Domestic Purpose Benefit; however this ceased with a change of case manager.

Dana spoke of her depression as something that these days would come and go particularly around winter and Christmas. She spoke of the impermanence of depression and knowing that it is not constant helps her to cope with the feelings of powerlessness she experiences alongside it. Dana spoke of her experiences with the self development course that she undertook as being beneficial to her managing her negative thought patterns and about the profound effects she felt from taking the herbal medicines. Although Dana had an off putting experience with her first visit to a

herbalist, she continued with two-three visits to the second herbalist as she was found it was hugely beneficial for her. Dana spoke of her “faith in the herbs” and the things that she “regarded to work such as natural therapies”. As well, Dana perceived the way that a herbalist might put their perspective across to a person to have a bearing on their overall healing.

Yep and just that instilling hope that “hey its gonna be ok and you’re gonna pull through this” which I think is such a vital; well its part of the herbs actually working, cos it sort of perhaps instills in people a faith about the medicine and when they’re taking it they’re holding that in their mind as well. Yeah.

Overall Dana perceived the holistic approach as efficacious as there is the opportunity to be seen by the practitioner from a broad perspective. Dana thought if required she needed a herbalist again, she would return to her second herbalist again and would recommend her to others.

Oh I like the long consultations. Yeah I do. It gives me a chance to blabber away about things and that’s all part of it you know, you pay someone to listen to you. And with the long consultations they (herbalists) get a better perspective of where you’re at in your life. I think that’s a good thing and you (they) get to understand what’s going on underneath. Also because it’s worked before and I believe in it as a tradition I guess.

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### Case Study Two: Emily

Emily is a 51 year old Pakeha woman who lives alone. She is a mother and a grandmother and currently employed as a full time professional writer. Emily decided to visit a medical herbalist six months after she had been diagnosed with a terminal illness. She was at a point in her life where she realized she may not actually die from her illness

and wanted to make some lifestyle changes. Emily decided she wanted to address her health from a holistic perspective. She felt after a few misdiagnoses and the general manner of the orthodox health professionals that she “had lost a bit of faith”. Emily began to see a life coach. She wasn’t happy with what she was being taught by the life coach but did heed her recommendation to a particular herbal therapist. During the course of the herbalist’s assessment of Emily, he identified depression. Although Emily had experienced depression years before and was familiar with it, as she had been focused on her terminal illness she thought this time she had been in denial of her low mood.

*He always asked me “how are your moods?” and I always said “oh fine - I’m stoically determined”. I think he picked it up from other things like what was going on in my life and my state of health and things. My moods were like a roller coaster. There was the euphoria of thinking I was going to have a life after thinking I wasn’t but the difficulties of doing it on my own and the worries of my children and grand child were all just a burden. Everything was my responsibility. I wasn’t low to the point of dysfunction because I masked it by shortening my work hours to four days per week. I would really have gone over the edge if I worked five days as well.*

Emily presented with multiple causative factors to her depression. She had been diagnosed with a terminal illness, her marriage was breaking down as a consequence of the illness, she was experiencing difficulties with her son’s depression and she was working full time. Emily described her state as ‘not too serious’ as she had been given an opportunity to live and this motivated her to overcome the depressive symptoms.

*It was like being given another chance in a way, so I guess I fought my low mood. I felt I should because I was given this opportunity to live. It was a driving factor to get through it.*

Emily had a comparative gauge to the depth of her low mood, as she had experienced depression seven years previously and again four years previous. In these episodes of

depression Emily recalled feeling as though she “was made out of stone. Dead I suppose”. In both episodes Emily had been medicated with Prozac. She thought the Prozac relieved her of the need she had to overcome the depression of her own accord, which was a positive factor for her at that time.

*I think it helped me because I'm very much as head person. I tend to rationalize and be strong mentally and I felt I could over-ride it and the Prozac I guess gave me down time from that determination.*

Emily took Prozac for three months over her first episode of depression and for six months over her second episode. She described not enjoying the side effect of having enhanced libido as she was not sexually active at the time. As well Emily experienced some ethical ambivalence towards pharmaceutical medicines. On one hand she thought that they were valuable e.g., she had to take antibiotics for a life threatening kidney infection, and was grateful for this treatment, but on the other hand she struggled with her perceived lack of values of pharmaceutical companies. The unethical ethos of pharmaceutical companies she said, “contributed to a firm resolve in my choice towards natural medicines”.

Emily felt swayed towards her alternative choice by a moral standing; however, other factors also contributed to her decision to visit a medical herbalist. Although Emily was raised in a family who used conventional medical treatments she felt akin with following natural philosophies. Emily had tried alternative therapists in the past such as acupuncturists and chiropractors and did not feel that visiting a medical herbalist was a complete change. She did think however, that she began to follow natural modes more so after she was given the diagnosis of cancer.

*In the broadest sense like a lot of New Zealanders I don't feel like I have a specific culture but it makes a lot of sense for me to be close to nature, I'm a Greenie. I can't see any other way to be really. Prior to my cancer diagnosis I thought all these things (alternative philosophies and practices) were a good idea but didn't do anything about it. It (cancer) was like a catalyst to changing my evil ways. I'd always been open to them. It made sense. The holistic thing about*

*naturopathy really appeals.*

Emily visited her herbalist fortnightly for eighteen months. Her first two consultations took one and a half hours and then half hour to hourly sessions took place thereafter. Emily did not take any orthodox medicines during the treatment time-frame. During this time she engaged in a range of treatments suggested by the herbalist for physiological symptoms and psychological factors. Her treatment involved adherence to a strict dietary regime without processed foods, coffee, alcohol or sugars and included taking B vitamins, pro-biotics and omega three oils. As well, Emily took herbal formulas made from tinctures which were mixed at each consultation. Emily reported that her herbalist would enquire each time he mixed her herbal formula as to her mood status. She described the herbal medicine as “foul” and although the taste was aversive Emily was not deterred by this, taking it regularly. She described having “made a commitment to the therapy” which was expensive for her; therefore, she felt she wanted to take the medicine no matter the taste.

As well as following this physiological regime, Emily engaged in counseling with her herbalist. This generally involved discussion about what was currently going on in her life. She recalled discussing many stressing life factors and the herbalist facilitated formulating goals and problem solving issues. Emily thought she had a good rapport with him which helped her immensely. She discussed that he seemed like a regular type of person whereas others may have come across “a bit too new agey”. She thought this made him accessible to others as well. Emily perceived that people find counseling difficult but as her herbalist had a very easy manner this part of her therapy was unproblematic.

*He was making me think about what I wanted and what I needed rather than what I had. I see this very much as a part of the treatment for depression as it was closely linked for me. It always felt like a counseling session but not in an unpleasant way. I felt we had a good rapport; we were on the same level. Because we had such a good rapport and I had great respect for him, the whole philosophy and what he was doing, I think it (the counseling) had a huge affect on me: a*

*positive effect. I loved the lengthy consultations because of the counseling aspect. It sorts out what's important and what's not and when you get that clear I think the effect of depression is very different.*

Emily's herbalist discussed meditation with her which she did not take up. Although she was not opposed to meditation she preferred to have a "total me day" instead. While Emily was engaged in treatment with her herbalist she shortened her work from five days per week to four. The fifth day she would use for her consultations, beach walks, visiting friends, going to the hairdressers and have leisurely lunches. As she already walked regularly and attended dancing her herbalist did not encourage her to do any more exercise. They both felt that this area of her life was fine. She described having an analytical nature which had led to her reading a lot of books in the past and discussing meaningful topics with many people. For this reason Emily preferred her herbalist to discuss conceptually with her the rationale behind his recommendations then she would decide what to utilize for herself. That he engaged with Emily collaboratively from theoretical platform as well as on an individual level, was an approach that Emily perceived to work well for her.

*Mostly he made me feel like I had (personal) responsibility and he didn't talk down to me. He talked intelligently and treated me intelligently. He answered all my questions and he seemed to talk at that conceptual level easily and that's not to say that we didn't talk on a personal level as well. We got on very well.*

Emily thought her treatment with the herbalist was wonderful but not without its drawbacks. The biggest difficulty Emily found was the huge financial commitment. She was fortunate enough to have had some savings and used them for her consultations and supplements. As well, Emily missed some of the foods she was used to and disliked the medicine but understanding the rationale behind what she was doing helped her to supersede these discomforts.

*There were things I found hard but because the whole idea of naturopathy and the herbs as treatment and support to your body and*

*function made sense to me, I could over ride it. There were things I missed but I was better off without them. I did what I was told but not out of compliance. It just made sense to me.*

Emily perceived that the overall treatment was empowering. She had experienced being treated by a general practitioner, a surgeon and a dermatologist over a period of time. In comparison to these conventional forms of treatment Emily identified the holistic treatment as the best practice she had engaged in and that the herbalist was the best medical professional she had been treated by. She found it difficult to separate the treatment in terms of the physiological and the psychological aspects. She recalled that she had learned how to behave differently and how to live differently and that this was a key factor in the efficacy of the therapy.

*I had never been treated as a whole person before. The dermatologist would say “have you got any other lumps and bumps?” The surgeon would admire his handiwork and the GP would say “what can I do for you?” I didn’t feel confident in that at all. It felt like nobody gave a damn. I could see how the scar was, I know if the glands under my arms are swollen so all I could see to do was (work on) my general health and I wanted somebody to look at me as a whole person which he (herbalist) did. I felt empowered. It had an immense impact on me. I felt I learned a lot about myself and when you figure out what’s important, that has an immense impact upon depression.*

Emily discussed barriers to herbal medicine. Aside from the financial issues, she spoke about social barriers and how she thinks that pharmaceutical companies only want to fund research into chemicals. Emily expressed her wishes for every medical doctor to attain some training in the use of herbal and other natural medicines. In this way she thought that the arena of Complementary Alternative Medicines may extend to people with more scientific ideologies and gain more public faith. Although having some appreciation for aspects of orthodox medicines such as visiting her general practitioner for diagnostics such as blood tests, Emily declared that if she were to become unwell for any reason her “first port of call would be at the door of my medical herbalist”.

### Case Study Three: Lisa

Lisa is a thirty-five year old woman who identifies herself as a “New Zealander”. She is a university student and single mother of two children. Lisa has experienced depression, anxiety and panic attacks intermittently for most of her life. Lisa’s mood disorders began in adolescence. She never experienced positive emotional support from her family and throughout her years of low mood which included hospitalization for an attempted suicide when she was eighteen; Lisa’s parents maintained that she was “attention seeking” but agreed to medicating her. Lisa felt powerless over their decision as well as when to terminate the medication. Lisa continued to experience depression at different times and reluctantly used prescription medications such as Prozac and Citalopram for varying time frames ranging between two-three months to two years at one time. She did like the medications describing them as “a quick fix”. While experiencing her last major depressive episode Lisa utilized the services of a medical herbalist. This alternative treatment continued for two years throughout her low period and then into a pregnancy. Treatments then were targeted at health issues and prevention of Post Natal depression which Lisa had experienced with the birth of her first child.

At thirty one Lisa experienced a major depressive episode with co-morbid panic attacks. Multiple causative factors contributed to her mood state. She was working in a managerial position accruing a massive work load and too much responsibility and had recently broken up with an emotionally abusive and overly controlling long term partner. She was also enduring behavioural problems with her son who had begun acting similarly to her ex-partner and as a consequence was put on behavioural review at school. The stress had become too much and Lisa wasn’t coping. She describes herself at this time as “a real mess” and that this culminated in her having “a breakdown”. Lisa began visiting her doctor on a weekly basis and a counselor for only a brief period as she was not comfortable with the counselor wanting to discuss her own personal issues with her. Lisa’s doctor wanted her to take antidepressant medication which she was averse to although she knew she needed some help. Lisa’s resistance to the medication was due to negative effects she had previously experienced however she decided to recommence them. Lisa described “hating” the medication. She was a mentally active woman and disliked her cognitive faculties becoming slow. As well she had found Prozac to be addictive which she was most uncomfortable with. At her doctor’s suggestion she

decided to seek alternative ways to manage the depression so she could terminate the anti depressant medication.

*I don't like the way the medication affects me. My brain gets dull and it feels like a fog's over me. I didn't want that and I'd been told by people that there are other ways of dealing with it (depression). I knew that there was no quick fix for this time. This was going to be a full body, mind the works. It wasn't going to be a quick fix; it needed to be a long fix.*

Lisa's doctor was very supportive of her seeking alternative treatments and Lisa perceived this to be the initiating factor to finding a Complementary Alternative therapist. She wanted to visit a therapist that she would be comfortable with to embark on a long term holistic treatment program that would help her manage low mood states and anxiety. She was determined to find a more natural way to manage her depression and wanted it to be more permanent than medication.

Lisa had been raised with orthodox medicine and although she had never been to a Complementary Alternative therapist she had experimented with a few natural products before. At one stage she shared a flat with a young man who drank herbal teas, used herbal medicines and ate healthy foods. Lisa referred to him as being "a positive person who introduced me to natural healthy living". She also had a friend who was studying to become a herbalist and had read alternative health books that she borrowed from her. Lisa searched the internet to find an alternative treatment that would suit her and asked different people for recommendations to someone who practiced natural therapies and provided counseling.

After enquiring at a local health shop, Lisa was given the phone number for their resident medical herbalist. She rang and asked questions about what treatment she (the herbalist) may be able to provide for her and booked a consultation to assess whether she would be the right practitioner for her. Lisa attended the initial consultation which involved rapport building and an overview of a treatment plan. After this initial consultation she decided to engage with the herbalist and began weekly – fortnightly hour long sessions, for a multi

faceted treatment program. Lisa discussed with her herbalist that ultimately she wished to be off anti depressant medication. She followed a holistic program involving dietary requirements, herbal medicines and recommended supplements. She also engaged in counseling which was relative to her life situations and her disorder thereby becoming aware of personal triggers to her mood states and ways to manage them. Lisa learned a breathing technique to assist with levels of hyper arousal and was continually informed about the rationale behind what they were doing. She perceived the educative side of her treatment to be particularly helpful to her motivation and acceptance of the therapies.

*What made me feel better was having an education about why something is known to help with relaxation or what the reasons were for what I was doing.*

In addition to this, Lisa perceived her treatment to work in a holistic manner that slowly strengthened her emotional and physical health enough to wean off the prescription medication and naturally manage her depression.

*The whole process was supporting (me through) the depression, to get the body healthy, to get the mind healthy – to get me to a point where I could go off it (anti-depressant medication).*

At the time Lisa was overweight which contributed to low self efficacy and low mood therefore it was decided that Lisa would work on diet and exercise as well as mood. Lisa discovered while working on her diet that some foods would contribute to low mood or anxiety so she began to eliminate them. Her regular intake of white bread and other yeast containing foods was decreased along with highly processed foods and sugars. Lisa had regularly drunk energy drinks such as “V” but became aware of the adrenalised feelings she would get from them. She began to take Spirulina (a blue - green algae with a high protein content and concentration of vitamins, minerals and nutrients) instead, to increase her energy levels. Other supplements were recommended such as high doses of vitamin C and vitamin B complex to assist with adrenal support and nervous system function, which were reduced over time as Lisa improved.

In addition to the diet and supplements, Lisa took herbal medicines in the form of liquid extracts and tinctures. Lisa discussed with the herbalist at the outset of her treatment that she did not respond well to St John's Wort - *Hypericum Perforatum* and wished not to have it; therefore, nervines such as Chamomile – *Matricaria Recutita*, Lemon Balm - *Melissa Officinalis*, Green Oats - *Avena Sativa* and Vervain – *Verbena Officinalis* were used. She also took detoxification herbs such as Milk Thistle – *Silybum Marianum*, Violet Leaves – *Viola Odorata*, Dandelion – *Taraxacum Officinale*, Fenugreek – *Trigonella Foenum - Graecum* and immune supports such as Echinacea - *Echinacea Angustifolia* and *Pupurea* and Astragalus – *Astragalus Membranaceuos*. Her mixtures varied over time and changed according to Lisa's needs. As well as the herbal formula's, Lisa's herbalist provided Bach Flower remedies like Rescue Remedy for times of panic (Dr Edward Bach's formula for times of anxiety and panic containing White Chestnut - *Aesculus hippocastanum*, Clematis - *Clematis Vitalba*, Impatient - *Impatiens glandulifera*, Rock Rose - *Helianthemum nummularium*, Star of Bethlehem - *Ornithogalum umbellatum*). Lisa carried this with her to use when she became anxious, perceiving it to be helpful at these times. Lisa found the herbal medicines to be particularly supportive in assisting her emotionally and physically while she gradually reduced her anti- depressant medication.

Over approximately eight months Lisa weaned off her antidepressants until she ceased to take them at all. Throughout the whole treatment process, Lisa was supported with herbal medicines, supplements and counseling and her doctor. Lisa referred to her doctor and her herbalist working towards a common goal as “*a dual thing*”. Lisa continued with her herbalist until she felt she was stable. She appreciated the length of the treatment time frame and thought that she was able to make permanent change due to this.

*Well cures don't happen over night, treatment happens over a period of time and having someone where I was going over weeks to and getting the different medication for what was going on and consultations, isn't a quick fix.*

While Lisa was reducing her antidepressant medication she fell pregnant. For Lisa she considered this to be due to her improved health status; however, it was an unplanned

pregnancy and with it came new stresses. Lisa's alternative treatment took a different path including a pregnancy oriented diet, appropriate herbal medicines to maintain hormonal balance and a focus on prevention of post natal depression. One of Lisa's previous episodes of depression had been after her son was born and she feared a relapse. Lisa decided to seek out a midwife who would be compatible with her using alternative treatments and hoped that her herbalist would be of the same position. Lisa was successful with a compatible midwife – herbalist relationship. Throughout her pregnancy she continued visiting her herbalist to maintain her health status and to cope with the stresses that came with the pregnancy. Her treatment sessions became less frequent (three weekly) as she was utilizing the services of her midwife. Her baby was born and Lisa coped well. She considered many factors to be present to contribute to post natal depression, but it never occurred due to her alternative treatments.

*I personally believe that the fact that I got herbal medicine was the major reason I didn't get post natal depression. There were lots of things there that certainly meant that I should have got it.*

After Lisa's baby was born she continued to visit her herbalist for some time while gradually spacing out her consultations until she thought she was strong enough to manage independently. She would have liked to continue taking herbal medicines without consultations which was an option but it was not a financially viable one so she continued with the supplements that she could afford, her breathing technique and a problem solving method.

Lisa perceived the overall treatment to have had a permanent effect as she learned about strategies and alternative methods of support to utilize in low times. When Lisa was interviewed she mentioned that her last nine months had been difficult for her and that she had been experiencing low mood again. She was managing her mood status satisfactorily with the learned strategies but would preferred to have returned to her herbalist for extra support. Due to the expense she could not.

*I could have dealt with things a lot better over the last nine months if I had the herbal medicine as part of it but I've dealt with it a lot better*

*than what I would have prior to the treatment as it helped me to get healthier and provided me with skills to move on with depression, not let it affect me as much, to break it down, and little things I picked up like having the Vitamin C and extra minerals and things and what to take when you are feeling under the weather and all those little things. I think the whole process had had a lasting effect and impacts upon me now.*

Lisa discussed some of the key factors to the efficacy of her treatment. She liked iridology (iris diagnosis) in addition to verbal consultation and she thought the practitioner's approach was important. She wished to be given advice but wanted "suggestions and options" rather than being told that she "should be doing something". At times Lisa found the taste of the medicines particularly aversive and when she did, she would mention it. The herbalist always found a more compatible option without rebuking Lisa in any way for not having taken her medicines that week. Lisa thought it to be a positive factor that her practitioner was not afraid to double check with her literature resources to ensure she was providing the best option for her.

*For me I find it's about the knowledge, the training and the ability (of the practitioner) to understand at a different level.*

Lisa perceived her practitioner to provide her with ongoing support and whether she decided to use this or not she felt secure in knowing that support was there, particularly when she was expecting her baby. She referred to her therapeutic relationship as one of "trust". For most of the time Lisa did not know what was in the mixtures she was taking as both she and the herbalist thought it would be best that she didn't. Lisa would have continually researched what went into them and this may possibly have caused her unnecessary angst and time.

*I had full trust in my consultant to give me what she felt was going to be the right thing for me. It was- this is how I'm feeling, this is what's going on and she'd give me what I needed and it would always be right and it was an issue of trust.*

Lisa thought the counseling was a crucial component of the therapy. She discussed that her practitioner would listen to what she was saying then provide her with appropriate guidance and resources. If problematic situations were to reoccur with potential to precipitate disordered moods, Lisa would then be able to manage them more proficiently.

*All the way through I felt I was being heard, and not just being heard but was given advice on how to deal with things differently.*

When Lisa terminated her treatment it was because she felt she no longer needed to go. The counseling had reached a point of exhaustion and money had become an issue. Lisa discussed what she thought were barriers to accessing alternative treatments. For some of her treatment Lisa had been on a Domestic Purposes Benefit receiving extra assistance from Work and Income Support (WINZ) to have alternative treatments. This came about through her doctor writing WINZ a letter of recommendation for Lisa to visit a herbalist. Lisa discussed that it would have been very difficult for her to do this if she had not had her doctor's support and that for many, their doctors probably would not do it. She perceived this to be because "many people view alternative medicine as witchery and quackery". When Lisa became partnered with the father of her new baby she lost her WINZ assistance as they became a single income family. Complementary Alternative Medicines were then an unaffordable luxury. The cost was a factor for her to discontinue her treatment.

*I mean the political system has been set up so that like I said before, you can't get WINZ benefits to see a herbalist because it's classed as non-traditional. It should be the other way around – this is traditional because it's been around longer.*

These days Lisa does not experience low mood, anxiety or panic attacks to the severity that she did prior to alternative treatments and now manages her mood status with a lifestyle balance that includes a healthy diet, herbal medicines, anxiety reducing techniques and exercise. Although she thought the "whole process has had a lasting effect", from time to time Lisa still experiences disordered mood states when something

stressful is occurring and then utilizes the services of the same herbalist. Lisa views this as keeping herself safe. She also discussed that CAM is a way of life she will teach her children and has already introduced them to herbal medicines. Lisa recommends visiting a Complementary Alternative health practitioner to people she talks to who experience similar problems.

*I'm incorporating aspects of what I've learnt into their future as well so they learn it's a normal thing for them to do. If they feel unwell they can take something herbal or alternative rather than the run of the mill.*

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Case Study Four: Jan

Jan is a 48 year old Pakeha female. She is married with three teenage sons and is an at home mother. When Jan first visited her herbalist she had been experiencing chronic low mood. She spent one year visiting her herbalist each month for a one hour consultation and over this time reduced her depressive symptoms. She continues to practice the strategies learned she learned and occasionally visits her herbalist for check ups. She likes to stay on a herbal formula that she still gets from the herbalist to assist in maintaining mood stability and symptoms of menopause.

The first time Jan remembered experiencing depression was after her second son was born. She recalled not functioning at all well and visited a doctor who diagnosed her with post - natal depression. He advised her to “accept it, ride with not to fight it and if I (Jan) wanted, to go and get some professional help”. Jan recalled after her diagnosis the best thing for alleviating the depression was her husband, who was particularly supportive of her. She recovered from this depressive episode but years later it began to re-emerge.

Jan described a slow decline into a deep depressive state taking place over six years. As she had been experiencing fluctuating moods for some time, she always knew that a low ebb would only last a few days and she would feel well again. She began to

realize that she was depressed when she was “not bouncing back” like she used to and was perplexed as to why this was occurring. Jan felt very lonely although she always had family around her and she did not disclose the way she was feeling to anyone. With her previous depression she had discussed it with her husband and her doctor. Jan thought she became very good at “hiding how much of a struggle life had become”, telling no one. She recalled being “really tired and having real dark days”. Eventually Jan became afraid of the way she felt and of the path that she may go down if she continued to feel so bad. It was at that point that she decided she needed help and desired a way to obtain it naturally.

Jan had never used natural products or therapies but did not like the way she perceived doctors to “rush you in and rush you out”. In addition to this, she was vehemently determined to adopt a natural approach to avoid going on to antidepressants. She had not taken anti-depressants before but reported “I just prefer natural - it’s better for the body and the mind”. Jan had become familiar with the concept of natural products while reading health shops’ advertising that regularly appeared in her letter box. She recalled that although she often read the advertising, she was confused as there were so many products available and she had no idea what would be appropriate for her. She decided to take a visit to her local health shop and while talking casually, the retail assistant mentioned their herbalist to her. Jan booked a consultation with the herbalist at that moment.

The first consultation was the beginning of Jan’s recovery from low mood. She had not known why she felt so low and by disclosing personal issues to the herbalist who responded with some explanations, Jan perceived herself as regaining some control and understanding. After visiting her herbalist for a few consultations Jan became aware of her feelings of sadness. She had not realized that she had actually been sad and between them they discovered a precipitating factor to Jan’s depression, was that she had been missing her parents who had “passed on”. Two years prior to the beginning of Jan’s “downhill slide” her father had died; however, Jan thought she had grieved sufficiently and was not depressed over the loss. After discussions with her herbalist it was determined that Jan was very much missing her mother who had “passed on” when she was only 19. She found this a difficult concept to begin with

given the number years that her mother had been deceased. Jan began a treatment program that focused on attaining a better state of health as her energy levels were very low. As well, they worked on pertinent maintaining factors to the low mood. It was determined that Jan was experiencing some hormonal changes due to menopause, so this was factored into her treatments as well.

I didn't know why I was feeling the way I was feeling, it was like I had no control and after my first visit, well for a start it felt great because I knew I was getting some help and just talking to her and working through a lot of things that'd been just sitting in the background there really helped.

Physical health was addressed and collaboratively Jan and her practitioner worked at enhancing Jan's nutritional intake. The herbalist ascertained Jan's dietary deficiencies and requirements and ways for Jan to access what she needed through foods, herbal teas, water and supplements. Jan improved her diet with healthier eating patterns and took supplements such as vitamin B complex to assist with her energy levels and Omega three fish oils to help stabilize her moods. As well, Jan took herbal extracts and tinctures to help with her moods, to balance her hormone levels, to increase her poor circulation and to enhance her energy levels. She took her medicines daily which included herbs such as, Alfalfa – *Medicago sativa*, Black Cohosh – *Cimicifuga racemosa*, Chamomile – *Matricaria recutita*, Chaste Tree – *Vitex agnus-castus*, Dandelion root – *Taraxacum officinale* radix, Dong Quai – *Angelica sinensis*, Green Oats – *Avena Sativa*, Kava – *Piper methysticum*, Lemon Balm – *Melissa officinalis*, Lime Flowers – *Tilia spp*, Sage – *Salvia officinalis* and St John's Wort – *Hypericum perforatum*. Her formulas varied over time when her herbalist deemed it necessary.

In addition to the herbal formulas, Jan took Bach Flower Remedies including Gorse - *Ulex europaeus*, Hornbeam - *Carpinus betulus*, Mustard - *Sinapis arvensis*, Pine - *Pinus sylvestris* and Walnut - *Juglans regia*. After two weeks of being on a herbal formula Jan felt "livelier" and the puffy ankles and lower legs she had been experiencing, as well as some tingling, ceased. Jan found attending to her physical well being a pleasurable aspect of treatment. She enjoyed learning about nutrition and

taking the herbal medicines which were initially difficult to take but this immediate aversion passed after a few days as she became used to them. Jan soon began to enjoy them and liked the taste. Alongside improving Jan's physical health, other natural methods were included to enhance her mood status which included regular walking and some cognitive techniques.

Jan was taught to monitor her thoughts to "quieten my mind ". She referred to her mind at the time as "chattering a lot" and how it made her feel "overwhelmed". Her herbalist taught her to become aware of what she was thinking as well as a mind – stopping technique. Jan's herbalist also taught her how to use diaphragmatic breathing. She began to utilize these techniques and journaled her thoughts as suggested. Jan found these methods useful to "clear her way". She also took up a suggestion from her herbalist to read some "spiritual books" as prior to the depression this was an activity that she had enjoyed. Following a conversation in which her herbalist had mentioned the benefits of meditation, Jan found someone of her own volition to teach her and she began to meditate regularly. Although she was given a lot to do, Jan managed it all easily.

It sort of all has fallen into place and sort of happened without realizing. Like you begin to feel a lot better so you follow those ways that help you to feel better. I found it all good; I don't know, it's probably a combination but this time I felt it was just catered for me. And it was good to talk as well. Like you can go and buy something over the counter but I think it was good to work through a lot of things.

Jan discussed her herbalist as a key factor to her recovery. She felt "very confident and comfortable with her" and that the herbalist had offered her a lot of "good, helpful advice". Even simple activities that had been suggested such as regularly lighting a candle for her mother were perceived as helpful to Jan's "feelings of peace". Jan discussed that although her herbalist advised and suggested activities and health factors for her to employ, she had a sense of personal responsibility, in that, she was doing the work herself but with support.

I didn't have to take the medicine and I didn't have to go back, so well, it didn't feel like someone was coming up and doing it for you but it was good to know there was that help – it was also good to talk to someone who is non-judgmental and positive. I didn't feel like I was talked down to or anything, she was just very understanding and yeah, you could discuss things openly – I felt very confident and comfortable.

The outcomes of Jan's treatments were enduring. Her husband who has never been to a herbalist noticed a significant change in her. She spoke of several reasons for the positive results. That she had someone to talk to about how she was feeling and going for some help initially made her feel better. The herbal medicines were perceived as elevating her energy levels and mood. A big factor for Jan had been the tiredness and not knowing what was wrong. That these factors were addressed helped her to feel much better. A holistic approach worked well for Jan. She liked the discussion, the medicines and the Iridology (iris diagnosis). The techniques Jan learned, she continued to use. A holistic paradigm was efficacious for her.

Obviously I wasn't getting better by myself so to have someone to talk to openly about how I was feeling and then to be given herbal medicines which seem to really work for me, makes me feel so thankful. I can feel safe about myself now whereas before the path I was going down felt quite scary, confusing and dark. There are so many things that help me now – monitoring myself, awareness, watching my thought patterns and feelings, books that I read, herbal medicine, being aware of my breathing, being still, feeling peaceful; and having time alone – even though I don't feel alone.

Jan thought that taking things “one step at a time” was contributory to the lasting effects but also said if a similar situation were to reoccur, she would again visit a medical herbalist or perhaps a psychologist. The main reasons for this decision as opposed to going to a doctor were the opportunities to speak about how things were,

to be heard, and to be provided with natural medicines and counseling. She could not think of many barriers to seeking this form of treatment aside from people wanting “something quick” and that this was “a common mind set”.

If I did feel depression coming on, I would definitely go back. I wouldn't go to a doctor. I wouldn't want antidepressants and I don't know if they'd (doctor) really sit and listen and get to the core of how I was feeling. I would go to a psychologist but I'd rather just go back to the herbalist because it was all wrapped up into one.

These days Jan occasionally experiences sadness but is aware of it and feels that it is “ok to feel sad sometimes, without being depressed”. She thought that she had been depressed because she had “been trying to hold onto the past and panicking about the future”; whereas, now she thinks that she “loves and appreciates her past and enjoys what is at this moment”. Even though Jan has friends who live by orthodox medical practices, she still recommends herbalists to them as she feels that it helped her and she would like others to have the same opportunity. Although Jan rarely visits her herbalist now, she remains on herbal formulas provided by her to assist with the symptoms of menopause. She perceives them to help maintain her feelings of well being and said she “knows when the time will be right to stop”.

It feels quite neat not being depressed, I don't want to go back there.

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#### Case Study Five: Siobhan

Siobhan is a twenty – nine year old Pakeha woman. She is a single parent to her ten year old child and a full time university student. Siobhan experienced depressive episodes from the age of eleven which had predominantly been related to body and image issues. Siobhan tried various approaches to overcome her depression including counseling in her adolescent years and the most recent being a course of anti-

depressant medication, for a diagnosis of Major Depressive Disorder. Prior to this last episode, Siobhan had sought the services of a medical herbalist.

Siobhan was nineteen when she visited a herbalist for depressive symptoms. She had not long given birth and been ecstatic about being a new mother but was in an abusive relationship which had precipitated her low mood. At the time Siobhan sustained mixed feelings, as she was experiencing wonderful moments while she breast fed and bonded with her child but was waking up crying in the mornings and feeling extremely down about the relationship with her long term partner. She did not think that her depression was a post partum syndrome as she deemed the pregnancy and her baby to be protective factors but attributed this episode to the nature of the relationship issues. She described herself as feeling “just gutted and I had zero self esteem”. Siobhan decided to terminate the relationship and she and her baby moved back home with her parents. She felt better for about three weeks but after settling in she began to notice a decline in her mood. She became extremely low to a point where her future appeared hopeless and felt that there was no point in life at that time. She was gaining weight through comfort eating, sleeping much of the time and was teary for a big part of most days. Siobhan could not remember exactly how long she had been feeling down but thought it may have been between two weeks – two months when her mother recommended her to visit a herbalist and paid for her to see one.

Siobhan had been raised with Complementary Alternative Medicine. She spoke of her parents becoming oriented towards natural healing methods when she was eight years old and after that she was rarely taken to a doctor, nor received any more vaccinations. She described her parents as “hippyish” and that various alternatives such as positive affirmations and crystals were part of a family culture. Siobhan had always loved the active properties of plants and tried to create perfumes from flowers when she was a young child. Throughout her pregnancy she utilized the services of midwife also trained as a herbalist, who taught her how to make creams from Plantain – *Plantago* and Calendula - *Calendula officinalis* to heal a rash that she had. As well, Siobhan had read widely about herbal medicine. She decided to visit the herbalist for her low mood, as she believed it would work for her.

Siobhan visited a local herbalist and remembered feeling “in awe” of her being a qualified herbalist. She was not however, impressed by her manner and only went for one session. She recalled during the consultation which was approximately half an hour in length, that the herbalist asked her many dietary oriented questions. She told Siobhan that her nutritional levels were low and recommended what Siobhan described as “really basic stuff like fruit and veges” and Nettle – *Urtica dioica* and Oatstraw – *Avena Sativa* infusions. Prior to her consultation Siobhan lived on a diet consisting mainly of two minute noodles and did not believe nutrition to impact upon well being. As well the dietary advice, the herbalist provided Siobhan with a herbal formula to take for two weeks. Siobhan remembered feeling a great sense of hope when she left the consultation as she was doing something for her depression and felt as though there was hope again.

Over the next few weeks Siobhan improved her diet and took her medicine despite it tasting terrible. She recalled feeling better but could not say whether the herbal treatment had helped her or not, as she had incorporated strategies into her healing process as well. Siobhan wrote positive affirmations on cards to read and found these to be very beneficial as she would pull one out and read it to herself when she felt the need. She began to go out for coffees and lunches and shopping, as she had money due to living at home with her parents. Siobhan perceived to money to be a valuable remedial tool. She also found talking to people such as her mother very therapeutic. Siobhan self administered the remains of her Bach flowers of Rock Rose - *Helianthemum nummularium* which she had used during her pregnancy, as the herbalist had not provided her with any such remedies. In due time, Siobhan began to feel more like she was coping again and enrolled in a herbal medicine course to learn more about this form of healing. She did not return for a second consultation and thought that this was probably due to feeling better.

Siobhan perceived the most helpful aspect of visiting the herbalist was taking the first step to addressing her symptoms, thereby, feeling better. In addition; however, she perceived the dietary changes to have helped and discussed the value of learning about the potential impacts of food and nutrition upon mood. Siobhan did not

perceive the herbalist to be a particularly effective practitioner in that she had a very aloof manner. She did not feel well heard by her but in spite of this she did have confidence in what the herbalist was doing for her. Siobhan mentioned perceiving a difference in the balance of power between them rather than being on an equal basis but could not say whether it was the herbalist's attitude or whether it was due to her low self esteem at the time. She thought if she had shown more personal confidence the power differential possibly may have been less.

*I think if the herbalist showed a bit more empathy I would have felt more inclined to blurt everything out. I don't know if it was me or her manner - like if she had not been so aloof. I don't think I felt enormously heard by her but I have and do with other herbalists and other people in general. I just think it was her personal manner.*

Siobhan perceived the holistic approach as having had a significant bearing upon her recovery; however, this was an approach that she had adopted for herself as the herbalist had not provided her with a comprehensive program. Years later Siobhan experienced low mood again and this time followed the medical model. Her low mood was precipitated by giving up smoking, both cigarettes and marijuana, over the period of one month. She had smoked regularly since she was sixteen years old and in her late twenties decided it was time to stop. Once again she could not stop the crying and said she just "went down" as a great sense of loss overwhelmed her.

It was Christmas holidays at the time and Siobhan felt that her days were very long and very sad. In January she decided to visit her doctor. He was her family's doctor and was very supportive of her, in that, he knew she did not like prescription medication. This time however and despite fears of side effects and dependency, Siobhan wanted it. She thought that her depression had become a bigger issue than herbal medicines could address. She was put on to Citrilopram which she took for six months then slowly weaned off with the aid of herbal medicines such as Korean Ginseng – *Panax Ginseng*, Licorice – *Glycyrrhiza glabra*, Skullcap – *Scutellaria lateriflora*, and Vervain – *Verbena officinalis* which she purchased from a herbal

dispensary. With the support of the anti-depressant medication Siobhan felt that she had “got a break to change some things in my life”. She described experiencing minimal side effects from the anti – depressants of a skin rash, a gradual weight increase and flatulence. Although Siobhan used the herbal medicines to help her wean off the anti-depressants, she discussed that she prefers to use only one or the other form of treatments due to possible unpredictable interactions. She has not been to a doctor or a medical herbalist for depression since this last episode.

Siobhan discussed her thoughts about utilizing herbalists in the future. She perceived that some aspects of medical herbalism surpass doctors’ treatments; such as, the length of the consultation and the provision of plans for dietary and life style changes. That her doctor is usually rushed Siobhan perceived as a deterrent to consulting him, although she perceived the diagnosis and technology that the medical world provides to be a factor over visiting a herbalist. Alternative methods such as iridology and tongue diagnosis as practiced by herbalists were appreciated by Siobhan however. Siobhan perceived orthodox medicine to be “a bit dodgy, so a last resort”. Although she held these views about orthodox medication and discussed the amount of “medical mistakes” that occur, Siobhan also perceived that people generally hold “romantic kinds of views that they think they (herbals) are harmless” and when used without knowledge they are not. It appeared that Siobhan erred on the side of caution when consulting a practitioner of either model and she thought thoroughly about the conditions relative to each situation before making her choices.

Siobhan said she would recommend family or friends to visit a herbalist for treatment of depression, but she thought the practitioner played a big part of the therapy. In the same way Siobhan had perceived the herbalist’s manner to be paramount; she also perceived her doctor as a key factor to her recovery when she visited him describing him as “supportive and non-judgmental” to her views on alternative ways. She thought a herbalist who explained exactly how to take the herbal medications was particularly important for compliance, given that she found the medicines to be very distasteful and that they needed to be diluted.

*I mean I do know that the herbs work on their own regardless, but the added thing is the herbalist being caring.*

In the future, if Siobhan wished to visit a herbalist again, she thought that she would find it difficult due to the cost factors. She perceived it to be too expensive and wondered why Complementary Alternative practitioners are not subsidized for people on low incomes in the same way that chiropractors, physiotherapists and acupuncturists are.

*Yep herbalists aren't subsidized and the herbs aren't cheap so for people on benefits it's too costly and that really bums me out. It's way out of reach for low income people. The cost is a massive barrier. I mean how much does it cost to see a herbalist, about \$100 bucks? If it was subsidized yes I would definitely go more. I mean why they can't be subsidized?*

Currently Siobhan feels comfortable with her mental well being and occasionally visits a herbalist or self administers herbal medicines for physical health issues.

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Case Study Six: Moana

Moana is a 44 year old woman who is a practicing midwife and the mother of two adolescent children. She identifies herself as Maori. Moana experienced postnatal depression after both her children were born, with the first episode lasting twelve months and the second lasting three years, before she sought the assistance of a medical herbalist. At the time Moana did not realize that she was depressed but was noticing how exhausted she was and that she was catching colds and flues regularly. As well, she was experiencing memory lapses. One morning as she woke up, she noticed the sun for the first time in three years after the birth of her second child. Moana considered this to have been an awakening to the fact that something was not right and perhaps she was depressed.

Moana considered that her depression had been triggered by the birth of her second child but other contributing factors were also evident. She was living in an unhappy relationship with her husband who had a permanent illness and she was his primary care-giver which was extremely stressful. In addition to this, she perceived that differences in their cultures contributed to disharmony within their relationship. Moana was Maori and had been raised with Catholic values while her husband was an Irish - Australian Catholic; therefore, they had some very different ways to each other. In addition to this, they had been living with her husband's parents for five years which Moana deemed also to be a stress factor. While in this fifth year at her in-law's house and in Australia, Moana had her 'melt down' and sought Complementary Alternative treatment. This was a familiar paradigm for her.

Moana had been raised with both orthodox medicine on the behalf of her mother and with traditional Maori medicine from her father. She considered her alternative ways to have begun in childhood when her father would gather leaves, roots and ferns from the bush and infuse them or make poultices for whatever the condition at the time required. Although Moana's father was adept with his skills in bush medicines, it was the 1950's and 60's and Moana's mother was trying to break away from these traditional Maori ways. This contributed to conflict within the household for whenever Moana or her siblings had coughs or colds, her father would go to the bush for medicines while her mother would 'pooh pooh' his actions and take them to the doctor. When Moana was in her mid twenties and married she thought that most times they had been to the doctor over the years she had not noticed an improvement, so she decided to return the alternative ways of her father. Over the years Moana intermittently visited a herbalist for treatments for her children.

While Moana was living overseas she had chosen a herbal practitioner to treat her daughter for chicken pox. The same therapist had been treating her husband for various health issues. While living with her in-laws, her husband and her two young children, Moana decided to visit the herbalist herself as she had found her to be most efficacious and thought that she may be able to help her low mood. It seemed a

logical path to her as this practitioner had come to know Moana and her family and she did not want to visit a doctor.

I guess the reality is that none of the GP's that I had visited, I felt knew what to do for me and I suppose I didn't trust them because I didn't like their bedside manner. You know, they keep you waiting for however long it takes, hardly look at you, and wouldn't ask how are you? What's going on in your life? Nothing was applicable to how I would feel at that time of my life. They just asked for the symptoms and then prescribe, simplistic! They don't provide holistic care just one dimensional – just the surface, it seems a shallow way to treat somebody. It's more than physical; it's emotional, spiritual and mental.

Moana's herbalist was a Dutch woman who worked with herbal medicines, homeopathic medicines, nutrition, hypnotherapy and massage. Moana felt comfortable with her. As she had met her on a number of occasions she engaged easily with her in a comprehensive initial consultation. In this first session she was asked for a detailed account of herself, which included her medical and gynecological history, her family history, whether she smoked, drank or took drugs, various aspects of her physical status and what was troubling her. Moana's herbalist recognized that she was experiencing low mood.

I don't think she ever used the word depression with me but she did identify it with me. I knew I wasn't happy, I knew I was depressed but she didn't make big issue of it, she didn't label me at all, and I was grateful for that. I didn't want a debilitating label for sure.

Moana was provided with a comprehensive program. She engaged in twice weekly visits for the first three weeks, then weekly visits for a six week treatment frame overall. Her consultations were anywhere between twenty minutes to one and a half hours long depending on what was to be addressed at that time e.g., whether it was changing medicines or a maintenance session. Each visit included counseling and an action plan. Moana was taught self monitoring skills and strategies to follow through

with for troublesome situations. As well, she went onto a course of multi vitamins, vitamin C at a high dosage which was reduced after one week, Spirulina, Siberian Ginseng - *Eleutherococcus senticosus* in a capsule form, St John's Wort – *Hypericum Perforatum* in a liquid tincture, a constitutional formula, liquid zinc and they addressed nutrition. Moana was advised to do exercise for relief of stress and she had two hypnotherapy sessions. After the intensive six week treatment frame Moana attained a level of well being sufficient enough to take over her personal care. She continued with the medicines, the dietary monitoring and the strategies she had learned.

Throughout Moana's treatment her herbalist had been particularly supportive and readily available for her. Moana perceived herself to have been treated as an equal and although her practitioner was the expert in her arena, she empowered her to take personal control of her mental health. Moana felt as though she was 'the centre of the treatment, her plan was for me, it was about me' and that the herbalist taught her how to take responsibility for health and life decisions. As part of treatment, the herbalist also treated the rest of Moana's family. She had already been treating Moana's husband but decided it would be best to treat their children as well. Addressing the dynamics of the family unit brought about awareness for Moana as to where her responsibilities began and ended with regard to her husband's illness. While she had been working very hard to look after him, Moana's herbalist afforded Moana with space and he with more personal responsibility. Moana noticed the family dynamics improved after this systemic therapy. She liked that her practitioner had such a diverse range of skills and experience to apply.

Of all the facets of her treatment, Moana had initially found the hypnotherapy and dowsing (an alternative form of diagnosis based on energy fields) to be a little concerning, as they were not methodologies within her world view. As a Maori - Catholic such practices would have been 'frowned upon'. With regard to the dietary requirements, Moana perceived the zinc to be excessive as she had an organic vegetarian diet but decided as it was only going to be short term, it was not an issue. Compliance was unproblematic as Moana found everything easy to take with the worst element being the St John's Wort as it was 'a bit tart'.

Some time later after Moana's treatment had finished she parted company with her husband and returned to New Zealand with her children. Her practitioner continued to send medicines over for six months but Moana's income became reduced and she could not sustain the expense. She still experienced lows but was better able to cope with them with what she had learned and could reasonably implement. That the treatment was unaffordable was a catalyst for Moana to embark on a foundation course in homeopathy, to complete a course in massage therapy, to do an art therapy course and to become a midwife. In this way she gained the skills to be able to care for the health of herself and her children. Moana credits her herbalist with providing her with the encouragement to take this path and as someone who taught her how to recognize the warning signs of imbalance and ways to rectify it. The education and treatment Moana received from her practitioner was perceived by her as comprehensive and permanent. Overall, Moana perceived her as someone she could trust and someone who was actually interested in making her well.

I just think she was a wonderful individual. She gave unconditionally, she had the right blend of skills to help me and educate me. She helped to grow me up and for that I'm grateful. She certainly influenced the direction my life has taken, including the midwifery. I was depressed with both pregnancies, post natal, and I didn't know! I didn't know I was unwell because I didn't have a disease that needed to be medicated, just empowered.

Although Moana held strong beliefs in complementary alternative medicines, she also believed in pluralistic methods. She regarded both the medical model and the Complementary Alternative model were to be utilized as necessary. She thought that counseling should be a part of health care in general not just as with her treatment, for well being involves facets beyond just physical symptoms, such as, emotional states and contextual factors like the impacts of work. Furthermore, Moana discussed that she thought complementary alternative treatments should be more accessible to people. The cost factor was definitely a deterrent and for women with post – natal depression, particularly for first time mothers, it would be beneficial and more freeing

than conventional standardized treatment. As a midwife, Moana would like to have the autonomy to be able to refer depressed women to alternative therapists if they were subsidized and included as part of free maternity care.

Moana has visited a few herbalists since her treatment mainly for her children, but she did not perceive them to be as proficient as her first herbalist. She decided that she would not visit a herbalist again in New Zealand, as the same trust factor would not be there nor would there be the breadth of skills that her practitioner had. Moana discussed that she still gets down occasionally and then she employs the strategies that she learned, which maintains her equilibrium.

The treatment that she gave me allowed me to move through what was happening and to make changes in my life. It supported me and raised me up so that I was looking down on what was going on – it made me see things more clearly.

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## **CHAPTER FOUR: FINDINGS**

### CROSS -CASE ANALYSIS AND DISCUSSION

The following section summarizes and explores the findings of this research. A comparative analysis was undertaken across the case studies and emerging themes were related to the relevant literature. The purpose of the study was to explore the perceptions of a sample of New Zealander's about treatments they had received from medical herbalists for symptoms of low mood or depression. More specifically the research aims were focused on gaining information about why these types of treatments were chosen. Other aspects to be explored were those of the actual therapies. What was it about these treatments that the participants responded to and did they perceive them to be efficacious? I wanted to hear what the participants had thought about a therapeutic relationship when it is within the context of a holistic model or whether a holistic approach was perceived any differently to orthodox treatments. If so, was there one particular facet of treatment that appeared to be most effective or was this truly a holistic paradigm that was perceived? Also of interest to me, was CAM therapies from a social perspective and whether there were any barriers perceived with regard to accessing these services, should they be required.

Initially the themed and coded case studies were translated into tables which included details of the participants and various aspects of the treatments they received (refer tables; 11 – 20. pp 109 – 118). Summarized tables were then created from the original tables and are included in this discussion section (refer tables; 1 – 10). This research began with investigating why the participants had initially chosen to visit a herbalist for low mood, however; this discussion begins with the demographics of the participants, as the sample group immediately reflected previous research into CAM users.

#### Demographics

Of all the respondents to the advertised research project (approximately sixty phone calls, text messages and emails of interest), only the participants who took part in the study fitted the criteria of having been treated by a herbalist for symptoms of low mood or depression. Of the remaining females and of all the males that registered

interest, none had sought treatment by a medical herbalist, but instead had self medicated for their low mood symptoms with over the counter health products. The six participants in this study sample went to four different herbalists (refer table 11 and table 1 methodology). Dana and Siobhan went to the same herbalist that Dana first visited, and Lisa and Jan visited the same herbalist. Demographics of the sample group for this project showed results consistent with previous findings of CAM gender demographics, i.e., more women than men use CAM practitioners and in particular herbalists (Blais, Maiga & Aboubacar, 1997; Mackenzie, Taylor, Bloom, Hufford & Johnson, 2003; Garrow & Egede, 2006; Tindle, Davis, Phillips & Eisenberg, 2005; Wolsko, Ware, Kutner, Lin, Albertson, Cyran, Schilling & Anderson, 2000; Wu, Fuller, Liu, Lee, Fan, Hoven, Mandell, Wade & Kroenberg, 2007).

Furthermore, previous studies discuss that women consumers of CAM are usually aged between 25 - 49 years (Blais et al., 1997; Mackenzie et al., 2003; Garrow & Egede, 2006; Tindle et al., 2005; Wu et al., 2007). Alternativley Millar (1997) cites, 45 – 64 year old woman as the most frequent users of CAM. The participants in this study were aged between 29 – 51 demonstrating even more variance on age demographics. If all the cited demographic age groups for CAM are to be considered, it could be said that women all ages appear to utilise CAM therapies. In addition to gender and age factors; in New Zealand, non – ethnic consumers are reported to be more frequent CAM consumers than ethnic consumers (Ministerial Advisory Committee on Complimentary and Alternative Health (MACCAH), 2004). The sample in this study reflected this previous research with only Moana identifying with an ethnic cultural group, in this case Maori. As well, consistent with literature the women in the sample were well educated.

Astin (1998), Blais et al (1997), Mackenzie et al (2003), Garrow & Egede (2006), Tindle et al (2005) and Wu et al (2007), dicuss higher education amongst women to be the other most prevalent demographic variable for utilisation of CAM therapy. This was reflected in the sample with Dana, Emily Lisa, Siobhan and Moana, all being either qualified profesionals, or university students on the way to becoming profesionals. Research cites that women with higher education levels are possibly

more inquisitive people who like to have reasonable levels of autonomy over their health choices (Garrow & Egede, 2006)

As well as higher education, (Blais et al., 1997; Mackenzie et al., 2003; Garrow & Egede, 2006; Tindle et al., 2005; Wu et al., 2007), cite that higher income is linked to CAM consumers. This was not consistent with this study, however; as half the sample (Dana, Lisa and Siobhan) were single mothers receiving a Domestic Purposes Benefit when they visited their herbalists. That half the sample were low income earners while the other half did not mention their income, was more consistent with Wolsko et al's (2000) study in which they discuss that CAM use is not confined to any particular income group.

Reasons for choosing CAM treatments have been discussed in many previous local and overseas studies (Bone, 2001; Brems, Johnson, Warner & Roberts, 2006; Francis, 2005; Furnham, 2002; Kirmayer, 2004; Linde, Mulrow, Berner & Egger, 2005; Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH), 2004; Saks, 2005; Xu, Luo & Tan, 2004; Yarnell & Abascal, 2001). One of the research aims of this study was to explore why these participants choose to visit medical herbalists.

#### Reasons for choosing a medical herbalist

Various reasons were cited as influential to the participant's decision to visit a medical herbalist (refer Table 12) and in the summary Table 2 featured below.

Table 2: Reasons for choosing a medical herbalist

| <u>Reasons</u>                |                           | <u>Participants</u> | <u>%</u> |
|-------------------------------|---------------------------|---------------------|----------|
| Recommendations or influences | <i>Family / friends</i>   | 3                   | 50       |
|                               | <i>Health shop ladies</i> | 2                   | 33       |
|                               | <i>Life coach</i>         | 1                   | 17       |
|                               | <i>Doctor</i>             | 1                   | 17       |
|                               | <i>Mail outs</i>          | 1                   | 17       |
| Previous CAM treatment        | <i>Heterogeneous</i>      | 4                   | 67       |
| Did not want anti-depressants |                           | 4                   | 67       |
| Personal philosophies         | <i>Heterogeneous</i>      | 4                   | 67       |
|                               | <i>Pluralism</i>          | 2                   | 33       |
| Early influences              | <i>Orthodox medical</i>   | 3                   | 50       |
|                               | <i>CAM</i>                | 2                   | 33       |

|                                 |                         |   |    |
|---------------------------------|-------------------------|---|----|
|                                 | <i>Pluralism</i>        | 1 | 17 |
| Dissatisfied with Medical model |                         | 3 | 50 |
| Additional catalysts            | <i>Terminal illness</i> | 1 | 1  |

The most compelling reason for the participants to choose to utilize a herbalist for treatment of low mood was recommendations given by others, as all six women cited this. MACCAH (2004) reported 29.2% of the respondents in their 2002/2003 New Zealand Health Survey, chose a Complementary and Alternative Medicine (CAM) practitioner because they were referred by family or friends and that a further 12% were referred by their doctors. Whangapirita (2003) discusses in her studies of alternative therapies and traditional Rongoa Maori practices in Aotearoa/New Zealand; in most cases family facilitates initial experiences with CAM. In addition to these studies, research by the Clinical Oncology Group in New Zealand also reported similar findings and that the recipients of the referrals had followed through on them by seeking CAM therapies (New Zealand Medical Journal, 1987).

Within this sample group, Dana and Siobhan were referred by a family member and Moana chose to visit the same practitioner that her husband and children had been seeing. Lisa and Jan (same herbalist), were both referred to their herbalist by ladies on the counter of their local health shop. Lisa had initially been recommended to visit a CAM therapist by her doctor. Although she was alone in her referral source for this study, doctor's referrals have been reported in a number of studies as the facilitating factor to many people's visits to CAM therapists (Brems et al., 2006; MACCAH, 2004; Wu et al., 2007).

In addition to doctors' referrals, media has also been cited as being influential to CAM users initial decisions to utilise CAM practitioners (Cartwright & Torr, 2005; 2007). Jan could be seen to fit within this category, as she described reading all the mail outs she would receive, prompting her to visit a local health store. That all women were recommended to their herbalists by someone, intimates that choosing a CAM practitioner appears to be a contextual issue as discussed by Astin (1998).

Not only were referrals by friends, family or doctors identified as strong contextual 'push factors' as discussed by Cartwright & Torr (2005) and Furnam (2002), but

congruence with personal philosophies was also considerably influential to choosing to utilize a medical herbalist. While variance could be observed within the participant's belief systems, that the philosophies of the participants were akin with the holistic model supports Astin's (1998) research. Astin (1998) suggests, users of CAM very often hold cognitive or spiritual philosophies, which are congruent with a holistic approach, that views illness within a larger context of life meaning (Astin, 1998). Furthermore, Kirmayer (2004) discusses that efficacy of treatment largely lies in the meaning of the treatment for the person. Also relative to meaning, Astin (1998) discusses a bi-directional causation effect, such as; when a person has a world view that incorporates aspects of mind and spirit, they are possibly more likely to be attracted to CAM. On the other hand, when a person is accustomed to using CAM as their norm such as when they are raised with it, they may be more likely to become attracted to philosophical ways of thinking. Siobhan, Dana and Moana's earlier life influences included CAM that may in turn have led to the formation of belief systems congruent with a CAM paradigm. However, that the women also demonstrated diverse philosophies possibly demonstrates the bi-directional effect that Astin (1998) suggests (refer table 12).

Another interesting observation Astin (2003) makes is that of paradigm shifts. When a person undergoes a life changing experience such as with Emily's terminal illness and then her decision to try a herbalist, it is noted that this reflects a shift from one belief or set of beliefs about life to another, often broader and more spiritually inclined. Emily discussed the changed perspective she had on life after having experienced her illness and seeking CAM. She, as with Moana and Jan, discussed feeling dissatisfied with the medical model. This again reflects 'push factors' towards CAM therapy, as discussed by Cartwright & Torr (2005) and Furnam (2002).

In addition to these reasons, 50% of the sample Dana, Lisa and Jan, clearly did not want anti depressant medication. Lisa, Jan and Emily had for past experiences of depression been to orthodox medical practitioners. Lisa and Emily had used antidepressants which they perceived to be helpful at the time, but not preferable. Siobhan had previously tried counseling. While Siobhan had not wanted anti depressant medication when she first visited the herbalist, later when experiencing

another depressive episode she decided to try it. Research cites that preference for natural medicines rather than pharmaceutical anti-depressant medication often precedes the choice for a CAM therapist (Kune & Kune, 2005; O'Higgins, Glover & Corral, 2005; Pilkington et al., 2006; Rascoe et al., 2004; Wu et al., 2007). As low mood/depression was the experienced condition of this study, aspects surrounding the women's situations of depression were explored.

### **Depression factors present when visited herbalist**

This section was to identify precipitating and maintaining factors present with the participant's low mood/depression when they visited their herbalists. I was interested in determining why the participants had experienced depression in relation to visiting a medical herbalist i.e., were people presenting to herbalists for symptoms of low mood or perhaps post natal depression or major depressive disorders? Were their depression issues contextual issues or were they medical disorders that perhaps maybe better suited to psychologists, psychiatrists or G.P's? Similarities could be seen throughout the participant group with regard to their depression issues (refer table 3 appendices and table 3b below).

Table 3: Depression factors present when visited herbalist

| <u>Reasons</u>      | <u>Participants</u> | <u>%</u> |
|---------------------|---------------------|----------|
| Relationship issues | 5                   | 83       |
| Chronic             | 3                   | 50       |
| Previously treated  | 3                   | 50       |
| Multiple factors    | 3                   | 50       |
| Postnatal           | 3                   | 50       |
| Work stress         | 3                   | 50       |
| Sickness            | 2                   | 33       |
| Grief and loss      | 1                   | 17       |

Many factors are reported to contribute to depression, however; the most salient to this sample group was that of relationship issues (MHF, 2007; NICE, 2007; Pilkington et al., 2006; WHO, 2005). Three of the women (Dana, Siobhan and Lisa) had left their partners (and Lisa was with her next). In two cases the women were in

unhappy marriages which were compounded by sickness, e.g., Emily's terminal illness and Moana's husband's long term illness. Half the participants reported similar precipitants to depression in five of the situations, these being: chronic intermittent depression or they had been treated for depression at some stage in their lives before; their depression was precipitated by work stress or post partum syndrome, or they had experienced multiple causative factors. One participant (Jan), had experienced long term grief which had moved into low mood/depression. As well, she was experiencing hormonal changes with menopause and thought this was partly contributing to low mood. Freeman, Sammel, Clarisa, Nelson, and Hollander (2004) discuss results from their four year research into hormones and menopause. This demonstrated that due to the transition through menopause and the changing hormone levels that occur, a high number of women experience depression (Freeman, et al., 2004).

Precipitants to participant's depression were consistent with those cited by depression sources (MHF, 2007; NICE, 2007; Pilkington et al., WHO, 2005); however, it was interesting to observe that within this group, relationships were such a predominant feature. This may have been purely chance or it may implicate an area of further research into the demographics of CAM consumers. To date, research in the area of CAM and depression is limited. Roy – Byrne, Bystritsky, Russo & Craske (2005) discuss that amidst CAM consumers attending for depression or anxiety, there are high rates of Axis I DSM -IV- TR criteria disorders, that co-morbidity of more than one disorder is high and attendance by women suffering depressive symptoms due to breast cancer is high. Within this study six woman attended CAM treatments for depression. Overall, the women felt that the holistic treatments they received had been effective for low mood/depression. The treatments they received involved a number of actions they had to self - employ, as well as medicinal complements that had to be taken.

### Consultations

The format of the consultations demonstrated some variance, as well as some congruence, amongst the treatments that the practitioners and participants engaged in. (refer Table 14) and the summary Table 4 below.

| Table 4: Details of Consultations |                                  | Participants         | %   |    |
|-----------------------------------|----------------------------------|----------------------|-----|----|
| Length                            | <i>One hour</i>                  | 3                    | 50  |    |
|                                   | <i>between 20 – 120 mins</i>     | 3                    | 50  |    |
| Frequency                         | <i>Varied weekly – monthly</i>   | 4                    | 67  |    |
|                                   | <i>Once only</i>                 | 2                    | 33  |    |
| Duration of treatment             | <i>Heterogeneous</i>             | 6                    | 100 |    |
| Modalities                        | <i>Diet and nutrition</i>        | 6                    | 100 |    |
|                                   | <i>Herbal Medicines</i>          | 6                    | 100 |    |
|                                   | <i>Education</i>                 | 4                    | 67  |    |
|                                   | <i>Herbal Teas</i>               | 3                    | 50  |    |
|                                   | <i>Bach Flowers</i>              | 3                    | 50  |    |
|                                   | <i>Homeopathic Medicines</i>     | 1                    | 17  |    |
|                                   | <i>Family therapy</i>            | 1                    | 17  |    |
|                                   | Counseling                       |                      | 4   | 67 |
| Techniques                        | <i>Various</i>                   | 4                    | 67  |    |
|                                   | <i>Breath work</i>               | 2                    | 33  |    |
| Further recommendations           | <i>Exercise</i>                  | 3                    | 50  |    |
|                                   | <i>Vitamin B</i>                 | 3                    | 50  |    |
|                                   | <i>Omega Three Fatty Acids</i>   | 2                    | 33  |    |
|                                   | <i>Spirulina</i>                 | 2                    | 33  |    |
|                                   | <i>Vitamin C</i>                 | 2                    | 33  |    |
|                                   | <i>Various other supplements</i> | 2                    | 33  |    |
|                                   | <i>Seek counseling</i>           | 1                    | 17  |    |
|                                   | <i>Meditation</i>                | 1                    | 17  |    |
|                                   | Compliance                       | <i>Easy</i>          | 4   | 67 |
|                                   |                                  | <i>Unproblematic</i> | 2   | 33 |
| <i>Manageable</i>                 |                                  | 1                    | 17  |    |

The duration and frequency of the consultations varied widely between the participants. Half the women attended one hour long sessions (Dana, Lisa and Jan – same herbalist); whereas, half (Emily, Siobhan and Moana) attended from twenty minutes to one and a half hours, depending on what stage of their treatment they were at. The frequency of appointments varied from weekly to monthly sessions, also dependent upon the stage of the treatment phase. Two of the participants (Dana and Siobhan (same herbalist) only attended one consultation, however; the format of the consultations demonstrated similarities as may be expected when one form of CAM

was utilized e.g., that of medical herbalists. All consultations except with Dana's first herbalist and Siobhan's herbalist (the same herbalist), observed an integrative approach, including: diet and nutrition, herbal medicines, relaxation techniques, supplements, Omega three fatty acids, meditation, social aspects and homeopathic remedies. These integrative approaches are consistent with discussions in previous CAM research and are as taught by various schools (Australasian College of Health Sciences, 2004-2007; College of Naturopathic Medicine UK, 1998 - 2007; International College of Herbal Medicine, 2001; MOH, 2006; NZAMH, 2007; Pilkington et al., 2006; South Pacific College of Natural Therapies, 2006; Zuess, 2003 ).

In all cases, diet and nutrition was addressed and herbal medicines in the form of liquid extracts or tinctures were administered. The women who knew what was in their formulas or gave me permission to access the information from their herbalists, described a number of nervines, adaptogens, immune system and adrenal supporting herbs, with the exception of Jan whose mixtures included phyto-oestrogens for menopausal symptoms. The herbs the participants took are indicated for use in mild depressive symptoms (Mills & Bone, 2000; Rasmussen, 2002; Yarnell & Abascal, 2001). Dana, Emily, Lisa and Jan, all drank herbal teas and Dana, Lisa and Jan took Bach flower remedies. Moana digressed with additional engagement in both family therapy and homeopathic medicines.

With regard to additional modalities, counseling and various techniques were engaged in by Emily, Lisa, Jan and Moana (refer table 14). The additional techniques remained consistent with research into CAM therapies as outlined by Zuess (2003) and Pilkington et al., (2006). Meditation was recommended to Emily and Jan, and Lisa and Jan (same herbalist) both engaged in breath work. Four of the participants (Dana, Lisa Jan and Moana) were recommended to exercise, which is also discussed as beneficial to elevating low mood and anxiety (DeAngelis, 2002; Zuess, 2003). Half the participants again (Emily, Lisa and Jan – same herbalist) were recommended to take Vitamin B, which is suggested to be helpful to nervous system function as well as anxiety, and depression (Osiecki, 2002; Zuess, 2003). Moana, Lisa and Jan took Vitamin C, which is reported to support the adrenal system as well as boost

immunity (Osiecki, 2002). It is suggested that a low immune response may contribute to depressed mood (Zuess, 2003). Moana on the other hand took a multi-vitamin and both Lisa and Moana took Spirulina. Lisa and Jan took Omega three fatty acids, which are reported to assist in the elevation of low mood (Gibson, Brotchie & Heruc; 2006).

While the participants appeared to have treatment programs requiring a significant amount of personal input to adjunct techniques, as well as supplements and diets, they perceived the treatments to be unproblematic. Compliance was rated as easy by Dana (with both the herbalists she visited). It was described as being trouble-free by Emily, Lisa, Jan and Moana, and Siobhan referred to it as manageable. As all women adhered to their treatment programs, it was important to determine whether they perceived some relief for their low mood; therefore, this was queried.

#### Perceived Psychological and Physiological Relief

In all cases the participants reported that their low mood improved and that they began to manage stress better (refer table 5b).

Table 5: Perceived relief

|                           | Participants | %   |
|---------------------------|--------------|-----|
| Mood lifted               | 6            | 100 |
| Managed stress better     | 6            | 100 |
| Energy levels improved    | 4            | 67  |
| Felt physically healthier | 4            | 67  |

With four participants (Dana, Lisa, Jan and Moana) energy levels were reported to have increased and they all described feeling healthier. With Dana and the first herbalist she visited, she noticed a change in her mood and her energy levels. With regard to better stress management, Dana attributed this to the external course she was doing at the time; however, she did notice stress management improved after visiting the second herbalist, who gave advice that Dana perceived to be helpful. Dana did not discuss in her interview whether or not she had felt 'generally healthier'. Siobhan noticed that her mood improved and she was managing her stresses better but did not notice any change on a physical level. Lisa, Jan and Moana; however, perceived improvement on all levels. Reasons why the women perceived the improvements were discussed in the

interviews, to determine whether there were isolated causes to perceived efficacy, or whether it may have been a synergistic effect. As yet no one single variable is attributed to perceived efficacy of CAM treatments which may imply it is the holistic approach which produces an effect (Ernst, 2007).

### Perceived efficacy of treatment

Perceived efficacy is discussed by Astin (1998) as a potential determinant to the future use of a health intervention. Perceived efficacy of CAM therapies is purported in research studies (Astin, 1998; Furnam, 2002; MacLennan et al., 2006; Pilkington et al., WHO, 2001). Cartwright & Torr (2005); however, discuss that research on perceptions about what constitutes CAM efficacy, is scarce. Furnam (2002) adds to this by suggesting that as CAM research is difficult and costly, CAM researchers tend to focus on why consumers choose CAM, rather than what works or does not work about CAM. It was important for this study to identify what the participants deemed to be key components to treatment efficacy. Various themes emerged as participants discussed a number of features that they perceived to be important (refer table 16 and table 6 below).

Table 6: Perceived efficacy of treatment

|                           | Participants | %   |
|---------------------------|--------------|-----|
| Holistic approach         | 6            | 100 |
| Herbal Medicines          | 5            | 83  |
| Diet                      | 5            | 83  |
| Recommendations & advice  | 5            | 83  |
| Education                 | 5            | 83  |
| Therapist's manner        | 5            | 83  |
| Philosophical fit         | 5            | 83  |
| Consultation length       | 4            | 67  |
| Counseling                | 4            | 67  |
| Disclosure and discussion | 4            | 67  |
| Techniques                | 4            | 67  |
| Hope                      | 4            | 67  |
| Taking action             | 3            | 50  |
| Faith                     | 3            | 50  |
| Autonomy                  | 3            | 50  |
| Empowerment               | 3            | 50  |
| Other                     | 3            | 50  |
| Gradual progress          | 2            | 33  |

---

For all six women in the sample, a holistic approach was perceived as a key factor to the efficacy of their treatment. Zuess (2003) suggests that integrated treatments are important to efficacy for CAM and depression. Depression is a multifaceted phenomenon and outcomes from holistic approaches tend to reflect diverse behavioural, psychological and psycho-social changes. Furthermore, the Clinical Oncology Group (1987) discusses that patients' benefit from integrated approaches that accommodate cultural, social and emotional requirements. Psychological, physical and social elements were perceived as contributing to efficacy within this study, although the elements that the participants deemed to contribute to efficacy differed amongst them. Areas regarded to be important to perceived efficacy, included: herbal medicines, dietary modification, education about health and issues, further recommendations to follow, the therapist's manner and the way CAM therapies aligned with personal belief systems. Aspects deemed to contribute the most to the efficacy of the participants' treatments, have been noted in previous CAM research on efficacy (Astin, 1998; Cartwright & Torr, 2007; Ernst, 2007; Kirmayer, 2004; McLennan et al., 1996; Mills & Bone, 2002; Wu et al., 2007).

In addition and also consistent with previous CAM research, were other areas highly regarded as efficacious, such as: the length of consultations, counseling, discussion, cognitive techniques and hope building (Cartwright & Torr, 2007; Kune & Kune, 2005; McLennan et al., 1996; Zuess, 2003). Moana did not mention the length of the consultations as pivotal to efficacy, but discussed that they fluctuated in length and were always sufficient to cater for her needs at the time. Half the participants perceived taking action as an important factor to becoming well again and half again discussed their faith in the process or the herbal medicine. Kirmayer (2004) discusses, that due to connotations of meanings for people relative to their chosen modes of healing; making a commitment to engage in treatment may promote a value position in an autobiographical narrative and thereby facilitate perceived efficacy.

Participant's contributed further by providing additional aspects that they perceived to be helpful. While two added that they liked Iridology (Jan and Lisa – same herbalist),

Jan felt the exercise was facilitative to her enhanced well being and Moana appreciated the family approach. Moana perceived nearly all aspects of her treatment as efficacious and held her practitioner in very high regard. Half of the participants (Dana, Emily and Moana) discussed that feeling empowered was important to them. Half the women again (Emily, Jan and Moana), deemed autonomy to be an important reason as to why the treatment had been efficacious for them. Empowerment and feelings of autonomy were fostered through the therapeutic relationship, between the practitioners and the participants. As the practitioner's approach had featured so critically in Cartwright & Torr's (2007) study, it was imperative to explore this theme in depth, in this study.

#### Practitioner Approach

Results in this section demonstrated participant's perceptions about different facets of their practitioners. In all cases, the participants reported confidence in their practitioner's abilities (refer to table 17 and table 7 below).

| <u>Table 7: Practitioner approach</u> | <u>Participants</u> | <u>%</u> |
|---------------------------------------|---------------------|----------|
| Confident with therapist              | 6                   | 100      |
| Trusted therapist                     | 5                   | 83       |
| Felt supported                        | 5                   | 83       |
| Felt heard                            | 4                   | 67       |
| Power equity                          | 4                   | 67       |
| Facilitated autonomy                  | 4                   | 67       |
| Other                                 | 4                   | 67       |
| Empathy                               | 3                   | 50       |
| Gave hope                             | 3                   | 50       |
| Pluralism                             | 1                   | 17       |

All of the women except Siobhan, and including Dana with her second herbalist, discussed that they 'felt supported' by their practitioners. Furthermore, Dana, Lisa, Jan and Moana described 'feeling heard'. Cartwright & Torr (2007) discuss that long consultation sessions provide an environment where a client may have space to discuss and feel. Additionally, the support that is often provided in CAM enhances feelings of positive social networks; therefore, it may be surmised that this will increase social reinforcement and feelings of well being. Emily did not mention feeling heard, but discussed that the conversations she had with her herbalist, were

valuable. This implies that her practitioner was possibly a good communicator and a good listener as well. Dana (and her second herbalist), Emily, Jan and Moana, all felt that a more equivalent level of power between them and their practitioner made for a better therapeutic relationship and that the self responsibility that was encouraged had been a good thing. This aligns with research by Cartwright & Torr (2007), who discuss positive outcomes emerging through more evenly balanced power differentials.

Not only were power equities referred to, but that the practitioner was empathic and gave hope was discussed by Dana (second herbalist), Jan and Moana. Moreover, four women gave additional reasons that they felt were beneficial to their treatment. Dana appreciated her herbalist being unshockable (second herbalist); Emily liked the way her herbalist spoke conceptually; while Moana felt comfortable as her practitioner did not give her a diagnostic label. Furthermore, both Dana (second herbalist) and Lisa, mentioned that they liked the way their practitioners had checked their literature sources in front of them (refer table 17). Although the participants perceived predominantly positive approaches on behalf of their practitioners and perceived treatment efficacy, there were some aspects of their treatments that they were less keen on.

#### Aspects of treatment perceived as less pleasing

Overall there were only a few areas that the participants had been less satisfied with (refer table 18 appendices and table 8 below).

Table 8: Aspects perceived as less pleasing

|                          | Participants | %  |
|--------------------------|--------------|----|
| Taste of Herbal Medicine | 3            | 50 |
| Practitioner's manner    | 2            | 33 |
| Dietary changes          | 1            | 17 |
| Alternative methods      | 1            | 17 |

Three of the participants (Dana, Lisa and Siobhan), thought the medicine was disgusting and Emily found the dietary changes difficult as she missed certain foods. Both Dana (first herbalist) and Siobhan (same herbalist as Dana), were put off by the practitioner's manner and Moana was initially dubious of the hypnotherapy and the

dowsing. As participants had expressed that they were less keen on these areas of treatment further exploration into whether they perceived these aspects to be deterrents to treatments by herbalists was undertaken.

#### Perceived barriers to utilizing the services of a medical herbalist

The perceived barriers to treatment could be divided into five main areas as shown in Table 19 and Table 9 below.

| <u>Table 9: Perceived barriers</u> |                                                           | <u>Participants</u> | <u>%</u> |
|------------------------------------|-----------------------------------------------------------|---------------------|----------|
| Expense                            |                                                           | 5                   | 83       |
| Taste                              |                                                           | 2                   | 33       |
| Practitioner approach              | <i>More training/expertise required</i>                   | 2                   | 33       |
|                                    | <i>Manner</i>                                             | 2                   | 33       |
| Other                              | <i>Empirical research and research – funding required</i> | 2                   | 33       |
| Attitudes                          | <i>Stereotypes</i>                                        | 2                   | 33       |
|                                    | <i>Lack of understanding</i>                              | 1                   | 17       |
|                                    | <i>Prefer quick approach</i>                              | 1                   | 17       |
|                                    | <i>Not taken seriously</i>                                | 1                   | 17       |

The strongest deterrent perceived to people utilizing the services of a medical herbalist was mentioned by Dana, Emily, Lisa, Siobhan and Moana. All five women thought that the expense of visiting a CAM therapist was a big barrier. This was a departure from the literature, which discusses high income earners as frequent CAM users (Blais, et al., 1997; Mackenzie et al, 2003; Garrow & Egede, 2006). Consistent with Rascoe et al, (2004); however, it appeared that CAM treatments were highly valued as participants either continued regardless of the expense or said that although it would be financially difficult to visit CAM therapists in the future, they would still prefer to utilize this form of treatment.

Four of the women (Dana, Lisa, Jan and Siobhan), perceived general negatively held attitudes about herbalists, and felt that herbalists are often stereotyped or misunderstood in society. Jan added that in today's society people like things to happen quickly and this generalizes to health issues. Jan's thoughts reflected Kirmayer's (2004) research, as he discusses how traditional health systems have become globalized and cultural links to healing are gradually becoming stressed.

Although research does not appear to explore societal attitudes towards CAM, Kune and Kune (2005) discuss that frequently held over enthusiastic attitudes on behalf of orthodox practitioners about the lack of empirical evidence for CAM, may possibly be influential to misconceptions about CAM therapies. This implies that education of both doctors and CAM therapists, may be facilitative to acceptance and correct implementation of different modes of healing. In this way, pluralism may co-exist as is evidenced in the United Kingdom with integrated palliative care (Saks, 2005). In addition, to these wider ranging attitudes, CAM practitioners may also be a deterrent for accessing the services of herbalists, when they are either inexperienced or with poor manner.

Both Dana and Siobhan thought that the practitioner's manner may be a barrier to those seeking CAM treatments, particularly if they are unempathic. Dana and Siobhan had visited the same herbalist and both found her manner off putting. This may have reflected that particular practitioner's personality, as Dana had not found her second practitioner to have an inattentive manner but instead found her approach to be very helpful. However, this is not to say that when a practitioner is of a brusque approach it will not be a deterrent to their further utilization, or that they would be recommended to others. Further to the practitioner's manner, both Dana and Moana thought that a lack of training or experience may be a deterrent to others wishing to engage with CAM therapies.

On a physical level, herbal medicines were suggested as possibly being off putting to people. Although three of the women despised the taste of the medicines, only two (Lisa and Siobhan) thought that they may be a deterrent to others choosing to use medical herbalism. While the women in the research had perceived some barriers to utilizing herbalists they all reported CAM therapists to have their place in society and that their treatments had impacted upon their lives.

#### Implications of the experience

All the women in the study felt that their treatments had impacted upon their lives in some meaningful and lasting way (refer Table 10 appendices and Table 10b below).

| <u>Table 10: Implications of the experience</u> | <u>Participants</u> | <u>%</u> |
|-------------------------------------------------|---------------------|----------|
| Further utilization of a herbalist              | 5                   | 83       |
| Used with children                              | 5                   | 86       |
| Would utilize medical pluralism                 | 4                   | 67       |
| Would recommend to others                       | 4                   | 67       |
| Would like to see CAM subsidized                | 4                   | 67       |
| Would like to see more CAM research             | 2                   | 33       |
| Facilitated education into CAM                  | 2                   | 33       |

Lasting effects from the impact of engaging in CAM is discussed by Cartwright & Torr (2007). Overall, the effects are said to be perceived on several levels of functioning, such as with physical, psychological and social outcomes (Cartwright & Torr, 2007). Cartwright & Torr (2007) refer to this phenomenon as the expanded effects of care. As well, it is discussed that long term effects from CAM therapies, not only impact in the reduction of negative symptoms but aid the prevention of further ill health (Cartwright & Torr; 2007). Dana, Lisa, Jan, Siobhan and Moana reported they like CAM for their children, albeit Dana, Siobhan and Moana and Dana had already begun using CAM for their children before they received treatments for low mood. Dana, Emily, Lisa, Jan and Siobhan suggested they would utilize the services of a herbalist for a similar condition again, or for other health issues. That they would further utilize services of a medical herbalist remains consistent with suggested reasons for choice of CAM therapists due to positive past CAM experiences (Williams and Calnan, 1996). The same five participants (Dana, Emily, Lisa, Jan, and Siobhan), also stated that they had and would, recommend visiting a herbalist to others if they were experiencing low mood. Emily, Lisa, Siobhan and Moana would or do utilize medical pluralism.

In order to access equal services of CAM and orthodox medicines, Dana, Lisa Siobhan and Moana mentioned that they would like to see CAM subsidized as part of the New Zealand health care system. At the time of visiting their herbalists Dana, Lisa and Siobhan were single mothers in a low income bracket and made mention of the fact that if CAM was subsidized as it is in other countries (Australia, Britain and parts of Canada), it would be a more accessible option; therefore, possibly frequented more often. Moana who is a mid – wife, discussed that she would like the liberty to

offer CAM as a post natal care option, as presently there is little aside from antidepressant medications to legally offer new mothers, who sometimes may just need some intermediary health option. These views are consistent with researchers Cartwright & Torr (2007), Fox (2005) and Saks (2005) who encourage more CAM options into the public health arena. In addition to the implications discussed, after visiting their herbalists, Siobhan and Moana chose to take up CAM studies for themselves. Dana and Emily, discussed that they would like to see more CAM research carried out in an empirical manner to improve the CAM knowledge base. This, as Ernst (2000), Kune & Kune (2005) and Saks (2005) contend, is a matter of funding.

#### Unanticipated Findings

Reasons that were relevant to women experiencing depression were initially prominent within this study. Past research into demographics illustrates that women frequent CAM practitioners more than men (Mackenzie, Taylor, Bloom, Hufford & Johnson, 2003; Tindle, Davis, Phillips & Eisenberg, 2005; Wu, Fuller, Liu, Lee, Fan, Hoven, Mandell, Wade & Kroenberg, 2007; Wolsko, Ware, Kutner, Lin, Albertson, Cyran, Schilling & Anderson, 2000). Reasons why women visit CAM therapists other than demographics, are limited. Wu et al., (2007); however, discuss that CAM use is high amongst females with depression.

Within this study it appeared that in a number of cases, the etiologies for low mood/depression that the participants experienced, were due to relationship issues, post-natal depression and menopause. It was also discussed by Moana that she thought CAM would be a valid post natal health option to offer to women and all but one participant reported using CAM for their children. These findings demonstrated an unanticipated relationship between CAM therapy, women and depression. This may indicate a possibility for future research. How many women in Aotearoa/New Zealand frequent CAM therapists for low mood/depression and are they receiving adequate and safe treatments?

### Limitations of the Research

A number of limitations were apparent within this study and have been considered. The sample size in the study was small but in addition to the size, four participants saw two herbalists between them, thus reducing the scope amongst practitioners. Four herbalists were visited in all, by the six participants. Within qualitative research however, Flick (2006) argues that to perceive a small sample size as a limitation places a qualitative study into a quantitative criteria. Flick (2006) discusses that the purpose of qualitative research is to develop new insights and theories through the quality of the research, rather than focusing on numeric results.

A further limitation within the sample was that two of the participants were past clients of mine and may have felt inclined to put across a more favourable reflection of their treatment. My reflection on this is that I thought these participants were quite forthright in their interviews with what they did and did not like about our consultations. I found it interesting, as I discovered perspectives about our treatments that I had not known. It is not usual, that a client discusses with their practitioner what they do and do not like, about the way the practitioner conducts their practice. Never the less, this factor may have influenced their descriptions and present a bias.

This sample demonstrated efficacy of CAM treatments hence shows a possible sample bias. To avoid this, it would have been interesting to have interviewed participants who had found CAM treatments to be ineffective. Alternatively, perhaps participants who had chosen orthodox treatments for low mood /depression over treatments by herbalists may have been interviewed as to why they chose not to use CAM. In addition, this sample did not include men. Of all the men who registered interest in the research, none had been to see a medical herbalist, but all had self administered with over the counter health products. This indicates an area for further research into men experiencing low mood/depression. Why is that they tend to self administer with natural products rather than seek therapy? If more breadth to the sample had been available, a more balanced overview of perceptions of CAM treatments would have been provided.

The last limitation to the research that emerged was as Flick (2006) discusses; while a semi structured interview allows access to an expanded range of information, it also meant at times some of the participants were inclined to digress onto other topics. As a consequence some areas of the research were discussed by some of the participants and not others.

## CHAPTER FIVE: CONCLUSIONS

This research project was to explore the perceptions people have about treatments they received from herbalists for low mood or depression. Thus, the research investigated why this group of people desired this form of treatment, how they found the treatments, whether they perceived any noticeable effects on their well being and what their thoughts for the future CAM are. This was not a research project to establish one form of healing over another. It was merely to explore the participants' thoughts about their experiences, and to gain insight to the realm of CAM and low mood/depression. The study has revealed some interesting areas for consideration with regard to health CAM in Aotearoa/New Zealand and with regard to further research.

Although considerable research has been conducted into CAM therapies overseas, it has more recently become apparent in Aotearoa/New Zealand, with the Ministerial Advisory Committee on Complementary and Alternative Health Care (MACCAH)'s discussion document in 2003 and their Advice to the Minister of Health in 2004. As well, demographics and satisfaction rates about CAM consumers in Aotearoa/New Zealand are included in the New Zealand Ministry of Health's 2002/2003 Health Survey. Overall, research conducted to date predominantly discusses demographics of CAM users, efficacy and debate about the safety of herbal medicines, with little research being conducted on how consumers perceive CAM treatments. This study was not intended to deliberate efficacy or safety but to explore the void in CAM research; that of consumers' perceptions.

While this study was not intended to explore in depth the demographics of CAM users, the sample did emerge as corresponding with previously conducted demographical CAM research. The participants were all women and mostly highly educated. All had experienced low mood or depression for a myriad of reasons; however, factors common to depression amongst women became apparent which were not evident in previous CAM research. For the most part, this included post-natal depression and also reoccurring depression over the course of a life time. In addition, relationship issues emerged as a common demographic factor amongst the

participants. Terminal illness featured, as one woman had experienced a major health issue and sought CAM therapy and another had nursed her un-well husband. In one case menopause featured; therefore, it might be surmised that as many menopausal women experience low mood/depression, other menopausal women experiencing low mood may present as CAM users in a larger sample. This is a possible area for further CAM research. Reasons why the participants chose CAM therapies were varied. A number of factors preceded the women's choices to visit CAM practitioners. These included; the influences of upbringing, previous past CAM experiences, or recommendations by families, friends, doctors and health shop assistants. All the women expressed either that they did not want anti depressant medication or that they had become dissatisfied with the orthodox medical approach.

With regard to how the women perceived their treatments, a number of themes emerged. The women primarily appreciated the holistic approach and the way a number of health issues were addressed including: diet and nutrition, herbal medicines for system restoration, psycho-therapeutic aspects such as counseling and various stress management techniques, and the therapeutic relationship. This meant for the women, that depression/low mood was treated as a set of symptoms brought about through psychological, physical, social and environmental circumstances, and were addressed from a multi dimensional approach. In addition to this, the education provided by their herbalists was regarded as beneficial. The effect of understanding illness and wellness from a holistic perspective assisted motivation to treatment and recovery.

Another theme I found particularly interesting was the impact of the practitioner's manner upon the perceptions the women held about the treatments. In all cases, regardless of whether perceived in a negative or a positive light, the practitioner impacted profoundly upon the way the women perceived their treatments. When the practitioner was deemed to have been perfunctory, it was regarded by these participants that this could be a deterrent to seeking CAM therapy. The women who felt discontented with their practitioner, nevertheless, felt pleased that they had taken action towards recovery and in spite of the practitioner's untoward manner they had confidence in the practitioner's knowledge and faith in the medicines. It was

suggested by some participants that more training may be necessary for CAM practitioners in the area of therapeutic rapport. On the other hand, the woman who perceived considerable efficacy regarded their practitioners to be proficient and it appeared that the practitioner's approach impacted significantly on motivation for therapy. For these women, they felt that they could disclose, discuss, receive help on a physical and psychological level and be well supported. This in turn enhanced feelings of empowerment, which were discussed as contributory to treatment efficacy.

For all the women in this study, their involvement with CAM practitioners had a significant impact upon on their lives. Those who perceived their practitioners as skilled and proficient still visit CAM practitioners when required and utilize medical pluralism. For the two women who considered their practitioners to be less than adequate, one went on to another herbalist and utilizes CAM therapies for herself and her child; whereas, the other commenced CAM studies and continues to utilize the medicines in a self administered way. She discussed that she would visit a herbalist again if required and utilizes medical pluralism. Although these two women deemed their practitioner as insufficiently skilled in therapeutic rapport, they still perceived relief of negative symptoms and attributed this to the medicines and making personal changes.

For all six women, relief was perceived for their low mood and their energy levels improved. As fatigue or lethargy is a symptom of depression; it stands to reason that as low mood improves so too should energy levels. Most of the women perceived efficacy in areas over and above mood and energy levels such as feeling physically healthier and managing their stresses better. As depression and CAM therapy are both multi-dimensional phenomena, such a synergism of treatment outcomes might be expected with integrated therapies. That these women perceived efficacy from their CAM therapy meant that they regarded this form of treatment as worthwhile and that its holds a significant place in their lives.

The women in the study discussed some pertinent implications of their CAM experiences. Predominantly, they continue to utilize medical pluralism as required.

Not only do they use medical pluralism for themselves but they also use it with their children. Mostly the women recommend medical herbalism to others they think would benefit from it. In addition to this and from a social perspective, four of the five women raised the opinion that they would like to see CAM therapies subsidized by our national health care system. The one participant who did not raise this concept, nonetheless discussed the immense expense of the treatment, given that she had been terminally ill and had to spend her life savings. The findings of this study therefore raised some overall implications.

### **Implications of the research**

This research demonstrated that women who experience low mood/depression may choose CAM therapies as a treatment option. Therefore, the research encountered several implications with regard to practice issues and health sector issues. These implications are discussed and juxtaposed with suggestions.

### Implications for future research

This study determined that although the New Zealand Health Survey (2004) cites one in four New Zealanders utilize CAM therapy, New Zealand research into CAM consumers is limited. Therefore, it is suggested;

- That more New Zealand research into CAM is conducted to obtain a more accurate representation of CAM consumers in this country.
- That as MACCAH (2003) outline in their study, appropriate methodologies be formulated to proficiently conduct CAM research.

As many studies discuss the lack of empirical evidence of CAM therapies, and as several studies implicate that CAM research is limited due to a lack of funding, it is hence suggested;

- That funding might be allocated by the Ministry of Health for further research into CAM.

The study also demonstrated that although both male and females responded to the research advertising, the respondents fitting the criteria of having visiting medical herbalists for low mood/depression were females. This therefore suggests;

- That a gender component to CAM treatments for low mood/depression may exist; therefore, CAM therapies, women and depression, may constitute an area for future research.
- That a gender component to CAM treatments for low mood/depression may exist for men who possibly prefer to purchase over the counter products and self medicate. This indicates an area of possible future research for men and CAM.

#### Implications for safety of CAM practice

The NZ health Survey (2003) discusses that one in four New Zealander's utilize CAM therapy. Statistics for women and men experiencing low mood/depression who utilize CAM practitioners are indeterminable, but as this study demonstrates, some women seek treatments by medical herbalists for these conditions. Women with low mood and depression are often in a vulnerable state of emotional health. Skilled and competent practitioners are facilitative to the reduction of negative symptoms and to the increase of a positive state of well being. MACCAH (2003) suggests that research into safety of CAM needs to be paramount. Therefore, it might be suggested that:

- Appropriate levels of training are implemented by CAM education providers to student CAM therapists, in depression/low mood. In this way CAM practitioners will know when CAM therapy is appropriate for a severely depressed client, so they may be referred on to psychiatrists, psychologists or doctors and thereby maintain safety for CAM consumers.
- That as some doctors practice CAM as an adjunct, education of orthodox health practitioners and CAM practitioners, includes a substantial component of drug-herb interactions. In this way, misadventure such as adverse reactions may be reduced.
- That mainstream practitioners become educated about CAM methods to eliminate bias and increase safety.

### Implications for the health sector

In 2006 a proposal was submitted to the Ministry of Health from the New Zealand Association of Medical Herbalists, requesting that medical herbalists be approved as a CAM profession and be included in the Health Practitioners Competency Assurance Act (2003). Invitation to comment was posted with a closing date of February 16<sup>th</sup> 2007. Whether this proposal was still in discussion could not be ascertained. The New Zealand Charter of Health Practitioners Inc webpage does not discuss their inclusion into the HPCCA. Therefore it is suggested;

- That regulatory bodies governing appropriate implementation of CAM therapies such as the NZ Charter of Health Practitioners and the NZ Association of Medical Herbalists be included in the Health Practitioner's Competency Assurance Act (2003).

In addition to implications for the health sector, as all but one woman suggested subsidy for CAM treatments, it is further suggested;

- That if future research also finds a substantial population of New Zealanders are suggesting subsidy for CAM therapies for themselves and their children, CAM subsidy ought to be considered by the Ministry of Health for CAM consumers.
- That CAM therapies such as medical herbalism, becomes a valid health option, so that health practitioners in other modalities (such as mid wives) who like to recommend CAM can do so with the assurance that they are recommending a legitimate option.

### Personal Reflections

It emerged that this research project was conducted similarly to Cartwright and Torr's (2005) study. It has generated insight into perceptions held by a small group of New Zealand women, who visited medical herbalists for treatment of low mood. The results from this research will support previous research findings into the physiological, psychological; social and moral elements that are suggested to be integral to people's recoveries over illness and contribute to a body of research that is slowly being developed. This is so that CAM approaches can be facilitated safely, equitably and successfully, for the positive well being of society as suggested by the Ministerial Advisory Committee on Complimentary and Alternative Health (2003) and by the World Health Organization (2001).

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## APPENDICES

### Appendix 1.

#### Interview Outline for: Clients of Medical Herbalists who have been treated for Depression.

##### 1. Introduction

- a) The researcher will introduce herself to the participant.
- b) The researcher will brief the participant on the aims of research project and ensure that the participants understand what the information will be used for; e.g., a Masters Thesis through the University of Waikato.
- c) The researcher will explain the measures taken to ensure participant confidentiality, e.g., use of pseudonyms and concealment of potential identification of clients.
- d) The researcher will explain the interview process and what she needs the participant to be speaking about, also that she will be audio taping the interview.
- e) Inform the participants that they will have the opportunity to read their transcripts and discuss them.
- f) Inform the participants that at any stage of the study they may call the researcher (collect for out of town participants) to clarify any concerns.
- g) Inform the participants that at any stage of the study if they wish to withdraw they may.
- h) Ask the participants to sign the consent form.

##### 2. Finding a Medical Herbalist

This part of the interview is to explore the reasons for people visiting Medical Herbalists. It is to find out what initially brings them to the point of seeking health treatments by way of herbal medicines.

##### Sample questions

*“I am interested in hearing why you initially sought the advice and treatment of a medical herbalist. Were there any particular reasons for your decision to seek this type of therapy?”*

- a) For what reasons did you engage in treatment provided by a medical herbalist?
- b) Had you heard of these treatments through whanau, friends, media or other?
- c) If you used both an orthodox doctor as well as your herbalist, what were your reasons for doing so?
- d) Were you already accustomed to using Complementary Alternative Medicine or
- e) Was it for cultural or spiritual reasons?
- f) Influences of past experiences with alternative or orthodox practitioners?

##### 2. Background

In this initial section of the interview I will be asking the interviewee to tell me a bit about their history of depression and how they came to seek therapy from a Medical Herbalist.

### Sample questions

*“I would like to begin the interview with you telling me a bit about the history of your low moods/depressive symptoms”.*

Aspects to be considered and prompted for would be;

- a) When you first visited your herbalist what sorts of symptoms were you experiencing? Physical? Psychological? Emotional?
- b) Had you ever been clinically diagnosed with a form of depression before e.g., Major Depressive Disorder; Dysthymic Disorder or a Major Depressive Episode?
- c) Had you ever received any form of treatment for depression before your alternative treatments?
- d) Had you ever visited a medical herbalist before you sought help for your depressive symptoms?
- e) Orthodox treatments and medications at the time and if so, what were they?

### 4. Consultations

This section of the interview is to enquire into the course of treatments people have engaged in with their herbalists.

### Sample questions

*“While you were visiting your Medical Herbalist what sort of a treatment program did you engage in? Tell me about how your treatment process began and progressed?”*

Appendix 2.

## Beyond Hypericum; *perceptions of treatments by herbalists for depression*



**Twelve research participants are needed**  
Are you interested?

Have you ever felt down, blue, or sad for no apparent reason and sought help from a Medical Herbalist? I am currently exploring the experiences of people who use or have used treatments by Medical Herbalists, for symptoms of depression. The aim of the study is to explore perceptions people hold about the efficacy of herbal treatments for low moods. If this sounds like you, would you be willing to share how you found this form of treatment with me?

If so, please take an information sheet (see below) and call to arrange an interview. All participants will go into a draw to win a free consultation with a medical herbalist of their choice, to the value of \$100:00. This study has received ethical approval from the University of Waikato.

Contact details;  
Kirsty Bell Hunter  
Ph: 07)847-1258

Email [kab15@waikato.ac.nz](mailto:kab15@waikato.ac.nz)  
Cell: 021 167 8617

Information Sheet for Participants of the Research Project

**Beyond Hypericum; perceptions of treatments by herbalists  
for symptoms of depression**

I am exploring the experiences of people who currently use or have used treatments by Medical Herbalists, for symptoms of depression. The aim of the study is to explore perceptions people hold about the efficacy of herbal treatments for low moods. Twelve participants will be invited to talk about their experiences with herbal treatments for depression. They will be required to give an audio taped interview which will take around 1 ½ to 2 hours. Interviews will be held in a private local location that both interviewer and the interviewee are comfortable with, e.g; in the participant's home or at the premises of their local herbalist, or in the researcher's office. A support person such as a family member or friend is welcome should you require one. All information will be kept entirely confidential. No material will be used in the report that will identify any participants. Participants will be informed of pseudonyms and will be provided with an opportunity to view and discuss their transcripts. Taped interviews will be destroyed on completion of the project. At any time throughout the research, participants have the right to withdraw, should they wish. The researcher offers that the participants may call her, or email, with any concerns or queries. Participation is entirely voluntary however a small token of thanks will be given by the researcher, as well as any transport costs incurred. A draw for all participants will occur at the completion of the project. The prize will be a free consultation with the herbalist of the participant's choice to the value of \$100:00. To arrange an interview please contact;

Kirsty Bell Hunter  
Email: kab15@waikato.ac.nz

ph: 07)847-1258  
cell: 021 167-8617

(Out of town call reverse charge. Please state on the phone that you are a potential research participant)

## CROSS – CASE ANALYSIS TABLES

Table 11: Demographics of Participants

|                | <b>Age at Interview</b> | <b>Gender</b> | <b>Culture and Ethnicity</b> | <b>Family Status at time of receiving treatment by herbalist</b> | <b>Occupation</b>             |
|----------------|-------------------------|---------------|------------------------------|------------------------------------------------------------------|-------------------------------|
| <b>Dana</b>    | 3                       | Female        | Pakeha                       | Single<br>One child<br>Living with parents                       | Professional analyst          |
| <b>Emily</b>   | 51                      | Female        | Pakeha                       | Single<br>Two children                                           | Professional writer           |
| <b>Lisa</b>    | 35                      | Female        | Pakeha                       | Living with partner<br>Two children                              | Mother and University student |
| <b>Jan</b>     | 48                      | Female        | Pakeha                       | Married<br>Three teenagers                                       | Mother and Home executive     |
| <b>Siobhan</b> | 29                      | Female        | Pakeha                       | Single<br>One child<br>Living with parents                       | University student            |
| <b>Moana</b>   | 44                      | Female        | Maori                        | Married<br>Two children<br>Living with in-laws                   | Midwife                       |

Table 12: Reasons for choosing a Medical Herbalist

|                | <b>Early influences</b>                              | <b>Previous CAM treatment</b>                                          | <b>Dissatisfaction with Medical Model</b>                            | <b>Did not want anti - depressant medication</b> | <b>Recommendations or influences</b>                                             | <b>Personal philosophies</b>                                                              | <b>Additional catalysts</b>                                         |
|----------------|------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <b>Dana</b>    | Mother's change to CAM in teen years                 | First herbalist then tried second (family member)                      | -                                                                    | Did not want antidepressants                     | Mother<br>Sister                                                                 | Opted for more alternatives in twenties                                                   | -                                                                   |
| <b>Emily</b>   | Orthodox medical                                     | Acupuncturists<br>Chiropractors                                        | "lost faith" after a few misdiagnoses                                | -                                                | Life coach                                                                       | Environmentalist<br>Wanted holistic approach<br>Ethics regarding pharmaceutical companies | Wanting to make life style changes after terminal illness diagnosis |
| <b>Lisa</b>    | Orthodox medical                                     | -                                                                      | -                                                                    | Did not want antidepressants                     | Doctor recommended<br>Friend studying herbalism. Internet.<br>Health shop ladies | Alternative spiritualist                                                                  | -                                                                   |
| <b>Jan</b>     | Orthodox medical                                     | -                                                                      | Doctor's too rushy and in-attentive                                  | Did not want antidepressants                     | Letter box mail outs<br>Health shop ladies                                       | Deemed natural as better for you                                                          | -                                                                   |
| <b>Siobhan</b> | Raised with CAM from eight years old. Family culture | Mid wife - herbalist                                                   | -                                                                    | Not to begin with                                | Mother                                                                           | Appreciative of aspects of orthodox and CAM                                               | -                                                                   |
| <b>Moana</b>   | Raised with orthodox and father was a "bush doctor"  | Father used natural medicines. Used herbal treatments for her children | Did not like one dimensional treatment by doctors or bedside manner" | -                                                | Already knew husband's and children's' herbalist                                 | Appreciative of orthodox and CAM                                                          | -                                                                   |

Table 13: Depression Factors present when utilizing herbalists' treatments

|                | <b>Chronic</b>                             | <b>Previous treatments</b>                              | <b>Multiple contributing factors</b> | <b>Post natal</b> | <b>Work stress</b> | <b>Grief and loss</b>   | <b>Relationship issues</b>                                                      | <b>Sickness</b>  |
|----------------|--------------------------------------------|---------------------------------------------------------|--------------------------------------|-------------------|--------------------|-------------------------|---------------------------------------------------------------------------------|------------------|
| <b>Dana</b>    | -                                          | -                                                       | -                                    | √                 | -                  | -                       | Had recently left partner but was not considered as a precipitant to depression | -                |
| <b>Emily</b>   | Re occurring episodes                      | Prozac                                                  | √                                    | -                 | √                  | -                       | Disintegration of marriage                                                      | Terminal illness |
| <b>Lisa</b>    | Since adolescence and post natal           | Prozac<br>Citalopram                                    | √                                    | -                 | √                  | -                       | Abusive relationship<br><br>Son's behavioural problems                          | -                |
| <b>Jan</b>     | Previous post natal<br><br>Gradual decline | No treatment<br><br>Husband served as supportive factor | -                                    | -                 | -                  | Long term sense of loss | -                                                                               | -                |
| <b>Siobhan</b> | Re-occurring since adolescence             | Counseling                                              | -                                    | -                 | -                  | -                       | Abusive long term relationship<br>Terminated relationship                       | -                |
| <b>Moana</b>   | Post natal                                 | -                                                       | √                                    | √                 | √                  |                         |                                                                                 |                  |

Table 14: Consultations.

|                                | <b>Length of sessions</b>                             | <b>Frequency</b>                       | <b>Duration of treatment frame</b> | <b>Modalities</b>                                                                | <b>Counseling and techniques</b>                  | <b>Further recommendations</b>                                              | <b>Compliance</b>                                                                          |
|--------------------------------|-------------------------------------------------------|----------------------------------------|------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>Dana</b><br>First herbalist | 1 hour                                                | One session                            | Three months                       | Herbal medicines                                                                 | -                                                 | Floradix                                                                    | Easy despite bad taste of herbs                                                            |
| Second herbalist               | 1 hour                                                | Casual                                 | Six months                         | Herbal medicines<br>Herbal Teas<br>Bach flowers<br>Diet                          | Advice                                            | Exercise<br>Counseling                                                      | Easy despite bad taste of herbs                                                            |
| <b>Emily</b>                   | First two = 1 & 1/2 hours<br>Following = 1/2 - 1 hour | Fortnightly                            | Eighteen months                    | Herbal medicines<br>Diet<br>Education                                            | Counseling<br>Goal setting<br>Problem solving     | Meditation (not taken up)<br>B vitamins<br>Pro -biotics<br>Omega three oils | Easy despite bad taste of herbs. Did not like word compliant-preferred 'made a commitment' |
| <b>Lisa</b>                    | 1 hour                                                | Weekly to three weekly                 | Two years                          | Herbal medicines<br>Bach flowers<br>Diet<br>Education                            | Counseling<br>Problem solving<br>Breath work      | Vitamins B & C<br>Spirulina<br>Exercise                                     | Easy despite bad taste of herbs – would change herbs if too bad                            |
| <b>Jan</b>                     | 1 hour                                                | Monthly                                | Twelve months                      | Herbal medicines & Teas<br>Bach flowers<br>Diet<br>Education                     | Counseling<br>Cognitive techniques<br>Breath work | B vitamins<br>Omega three oils<br>Exercise                                  | Unproblematic<br>Liked the herbs                                                           |
| <b>Siobhan</b>                 |                                                       | One session                            | Two week course of medicines       | Herbal medicines<br>Herbal Teas<br>Diet                                          | -                                                 | -                                                                           | Manageable<br>Herbs tasted bad                                                             |
| <b>Moana</b>                   | 20 minutes – 1 & 1/2 hours                            | Fortnightly x three weeks, then weekly | Six weeks                          | Herbal medicines<br>Homeopathic medicines<br>Diet<br>Education<br>Family therapy | Counseling<br>Strategies<br>Hypnotherapy          | Vitamin C<br>Multi vitamins<br>Spirulina<br>Liquid zinc<br>Exercise         | Unproblematic                                                                              |

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Table 15: Perceived psychological or physical relief

|                | Energy levels improved | Mood lifted | Felt physically healthier | Managed stresses better |
|----------------|------------------------|-------------|---------------------------|-------------------------|
| <b>Dana</b>    | √                      | √           | -                         | -                       |
| <b>1st</b>     | √                      | √           | -                         | √                       |
| <b>2nd</b>     | -                      | √           | √                         | √                       |
| <b>Emily</b>   | √                      | √           | √                         | √                       |
| <b>Lisa</b>    | √                      | √           | √                         | √                       |
| <b>Jan</b>     | √                      | √           | √                         | √                       |
| <b>Siobhan</b> | -                      | √           | -                         | √                       |
| <b>Moana</b>   | √                      | √           | √                         | √                       |

Table 16: Perceived Efficacy of treatment upon Mood and Well being - Key factors

|                                            | Dana            |                 | Emily                             | Lisa                                          | Jan                                             | Siobhan | Moana                  |
|--------------------------------------------|-----------------|-----------------|-----------------------------------|-----------------------------------------------|-------------------------------------------------|---------|------------------------|
|                                            | 1 <sup>st</sup> | 2 <sup>nd</sup> |                                   |                                               |                                                 |         |                        |
| <b>Consultation Length</b>                 | √               | √               | √                                 | √                                             |                                                 | √       |                        |
| <b>Holistic approach</b>                   |                 | √               | √                                 | √                                             | √                                               | √       | √                      |
| <b>Gradual progress</b>                    |                 |                 |                                   | √                                             | √                                               |         |                        |
| <b>Herbal medicines</b>                    | √               | √               | √                                 | √                                             | √                                               | Unsure  | √                      |
| <b>Diet</b>                                |                 | √               | √                                 | √                                             | √                                               | √       |                        |
| <b>Recommendations &amp; advice</b>        | √               | √               | √                                 | √                                             | √                                               |         | √                      |
| <b>Supplements or other modalities</b>     | Supplements     | Counseling      | supplements                       | supplements                                   | Supplements<br>Meditation<br>Reading<br>Writing |         | Supplements            |
| <b>Counseling</b>                          |                 |                 | √                                 | √                                             | √                                               |         | √                      |
| <b>Disclosure and discussion</b>           |                 | √               | √                                 |                                               | √                                               |         | √                      |
| <b>Techniques</b>                          |                 |                 | √<br>Goal setting<br>Prioritizing | √<br>Breath work<br>Identifying triggers      | √<br>Breath work                                |         | √<br>Stress management |
| <b>Education</b>                           |                 | √               | √                                 | √                                             | √                                               |         | √                      |
| <b>Taking action</b>                       | √               | √               |                                   |                                               | √                                               | √       |                        |
| <b>Hope</b>                                | √               | √               | √                                 |                                               |                                                 | √       | √                      |
| <b>Faith</b>                               | √               | √               |                                   |                                               |                                                 | √       | √                      |
| <b>Autonomy and Self responsibility</b>    |                 |                 | √                                 |                                               | √                                               |         | √                      |
| <b>Empowerment</b>                         |                 | √               | √                                 |                                               |                                                 |         | √                      |
| <b>Therapist's manner - rapport</b>        |                 | √               | √                                 | √                                             | √                                               |         | √                      |
| <b>Good fit with personal philosophies</b> | √               | √               | √                                 | √                                             |                                                 | √       | √                      |
| <b>Other</b>                               |                 |                 |                                   | √<br>Iridology<br>Weaning off antidepressants | √<br>Exercise<br>Iridology                      |         | √<br>Family approach   |

Table 17: Practitioner approach

|                | Empathic        |                 | Felt heard | Trusted practitioner | Confident with practitioner's ability | Well supported | Power equity | Facilitated autonomy or self responsibility | Pluralistic approach                                            | Gave hope | Other |   |                                                 |
|----------------|-----------------|-----------------|------------|----------------------|---------------------------------------|----------------|--------------|---------------------------------------------|-----------------------------------------------------------------|-----------|-------|---|-------------------------------------------------|
|                | 1 <sup>st</sup> | 2 <sup>nd</sup> |            |                      |                                       |                |              |                                             |                                                                 |           |       |   |                                                 |
| <b>Dana</b>    | -               | √               | -          | √                    | √                                     | √              | -            | √                                           | -                                                               | -         | -     | √ | Unshockable<br>Checked literature               |
| <b>Emily</b>   | -               |                 | -          | √                    | √                                     | √              | √            | √                                           | -                                                               | -         | -     | √ | Spoke conceptually<br>Respected him (herbalist) |
| <b>Lisa</b>    | -               |                 | √          | √                    | √                                     | √              | -            | -                                           | √                                                               | -         | -     |   | Checked literature<br>Suggested to - not told   |
| <b>Jan</b>     | √               |                 | √          | √                    | √                                     | √              | √            | √                                           | -                                                               | -         | -     |   | -                                               |
| <b>Siobhan</b> | -               |                 | -          | -                    | √                                     | -              | -            | -                                           | -                                                               | -         | -     |   | -                                               |
| <b>Moana</b>   | √               |                 | √          | √                    | √                                     | √              | √            | √                                           | Not mentioned as a key factor but herbalist was a trained nurse | √         |       |   | Felt very comfortable<br>Did not label          |

Table 18: Aspects of treatment perceived to be less pleasing

|                | <b>Practitioner's manner</b> | <b>Herbal medicine</b> | <b>Dietary changes</b>                                                                                                                     | <b>Alternative methods</b>                                               |
|----------------|------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <b>Dana</b>    | √                            | √                      | -                                                                                                                                          | -                                                                        |
| <b>Emily</b>   | -                            | -                      | Initially found giving up certain foods difficult but eased over time as Emily became accustomed to the changes and results were perceived | -                                                                        |
| <b>Lisa</b>    | -                            | √                      | -                                                                                                                                          | -                                                                        |
| <b>Jan</b>     | -                            | -                      | -                                                                                                                                          | -                                                                        |
| <b>Siobhan</b> | √                            | √                      | -                                                                                                                                          | -                                                                        |
| <b>Moana</b>   | √                            | -                      | -                                                                                                                                          | Initially unsure of hypnotherapy and dowsing but became accustomed to it |

Table 19: Perceived barriers to utilizing the services of a herbalist

|                | <b>Expense</b>                                                                         | <b>Taste of medicines</b> | <b>Attitudes of others</b>                        | <b>Practitioner approach</b>             | <b>Other</b>                                                                               |
|----------------|----------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>Dana</b>    | Not at the time as was a gift but would have been if self funded<br><br>Not subsidized | -                         | Stereotypes<br><br>Herbalists not taken seriously | bedside manner – more training suggested | Lacking empirical research to appeal to the majority of the population                     |
| <b>Emily</b>   | √                                                                                      | -                         | -                                                 | -                                        | Social barriers<br><br>Pharmaceutical companies only fund research into chemical medicines |
| <b>Lisa</b>    | √<br>Not subsidized                                                                    | √                         | Stereotypes<br>Doctors –many would not recommend  | -                                        | -                                                                                          |
| <b>Jan</b>     | -                                                                                      | -                         | People seeking a ‘quick fix’                      | -                                        | -                                                                                          |
| <b>Siobhan</b> | √<br>Not subsidized                                                                    | √                         | Lack of understanding                             | Practitioner’s manner if inappropriate   | -                                                                                          |
| <b>Moana</b>   | √<br>Not subsidized                                                                    | -                         | -                                                 | Some lacking expertise & experience      | -                                                                                          |

Table 20: Implications of the experience

|                | Facilitated personal education into CAM | Used with children | Would utilize medical pluralism | Further utilization of a herbalist<br>Has or would                                   | Would recommend to others                                  | Would like to see CAM subsidized | Would like to See more empirical validation of CAM |
|----------------|-----------------------------------------|--------------------|---------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------|----------------------------------------------------|
| <b>Dana</b>    | -                                       | √                  | -                               | √                                                                                    | Would tell personal story or recommend to second herbalist | √                                | √                                                  |
| <b>Emily</b>   | -                                       | -                  | √                               | √                                                                                    | √                                                          | -                                | √                                                  |
| <b>Lisa</b>    | -                                       | √                  | √                               | √                                                                                    | √                                                          | √                                | -                                                  |
| <b>Jan</b>     | -                                       | √                  | -                               | √                                                                                    | √                                                          | -                                | -                                                  |
| <b>Siobhan</b> | √                                       | √                  | √                               | √                                                                                    | √                                                          | √                                | -                                                  |
| <b>Moana</b>   | √                                       | √                  | √                               | Would go back to original herbalist<br>No – one perceived as proficient enough in NZ | No – one perceived as proficient enough in NZ to recommend | √                                | -                                                  |