

Health Doesn't Just Happen: the Time Crunch and Middle-Class Working Mothers' Use of Complementary and Alternative Medicine

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MARIAL Working Paper 18
April 2002

INTRODUCTION

It has long been acknowledged that the main source of health care is generated by the family (Starr 1982). Despite the great levels of technology that American medicine has achieved, there is sometimes no better treatment than a bowl of chicken soup. Like the American family itself, health care has been dramatically affected by changes in American society in the late 20th and early 21st century. Complementary and alternative medicine, once thought of as the domain of hippies, ethnic minorities, and desperate patients with fatal diseases, is widely accepted and used in the United States. This paper, as part of a thesis on the topic of complementary and alternative medicine (CAM)ⁱ, shows how this widespread use has been affected by and affects the modern American family.

The highest users of CAM are highly educated, higher income (middle class and above), non-minority women (Bausell, et al. 2001; Burg, et al. 1998; Druss and Rosenheck 1999; Eisenberg, et al. 1998; Oldendick, et al. 2000) (see table 1). This study looks at the population that are the highest users and solicits from them their motivations and justifications for this use. The population used in this study was non-minority, college-educated working women (specifically, schoolteachers). Schoolteachers were chosen because of their high level of education, because they had some degree of health insurance from their employment, and because of their tendency to belong to the middle class. The women in this study are mainly members of the middle class for the most part. Only two of these women would not be considered middle-class because of their family incomes. These factors were controlled with the intent of limiting the role education plays in their CAM use and also the role that cost might play in this use. In other words, this study was trying to avoid CAM health care use that was associated with expense only, rather than other motivations for use. Access to resources is related to expense, but also involves other factors (like availability of qualified health professionals, and access to pharmacies and other health treatment stores) that were limited in variation due to the more homogeneous nature of this sample. In addition, it was important to get a range in ages of women, to see if CAM use was associated with any phenomena relating to age.

BACKGROUND

There are some factors that provide background information on the population of CAM users and which makes the population used in this study especially important. In general, more women use health care than men do (Allen, et al. 2000). In addition,

mothers are major health care decision-makers for their families (Bull 2001). They also impart the rituals and myths of cultural health knowledge. A little over half of this population was mothers. Mothers and non-mothers alike, however, are working more hours than ever in the past (Cohen and Bianchi 1999). Both face the new types of daily stress and strain, balancing the challenges of home and work. This study intended, through this population, to draw out some modern day concerns or constraints that might provoke these women to use CAM therapies. As more women enter the work force, this population becomes increasingly more important to American life and the changing American family. The impact of these women's roles as teachers was not discounted. Teachers are an important part of the lay health care sector. They affect how children see the world, their roles, and appropriate ways to interact with their surroundings. Whether inadvertently or explicitly, they impart some of their knowledge and assumptions about appropriate health care to their students. In other words, health rituals and myths are largely affected by teachers. For example, they may tell their students what a healthy snack consists of or that they should wash their hands after they go to the bathroom to avoid spreading germs. All of these factors make this study population interesting and important to the work of the MARIAL Center.

THESIS STATEMENT

This thesis will show that non-minority, college-educated working women's health care choices are fundamentally shaped by their feeling of time deficiency and the need to gain control over this limitation. This concept, compounded by aspects of modern-day society, causes women to use "alternative" therapies to avoid or delay their use of biomedicine.

THIS STUDY:

Introduction

The results of this study are key to exploring how CAM use has been affected by modern American culture and relates to American family life. In an effort to focus on this role of CAM specifically, not all sections of this study will be explored. The study structure and the results concerning population characteristics will establish the extent of CAM use in this population and the trends that characterize this use. The section following these others, concerning sources for health care improvement, will describe the underlying reasons why these trends are evident.

Interview structure

The basic interview structure had seven sections: illness prevention, symptom treatment, long-term or chronic illness treatment, health education, health care influences, health care improvement and "alternative" medicine definition. In the first three sections, information was gained about what types of treatments the women use for different problems and their treatment hierarchy (or the order in which they choose to use certain treatments). The reasons why women have used these therapies at each level of treatment was obtained from these three sections and compiled. In other words, health care influences (or what these women said shaped their general health care outlook) has also

Number of women using for treatment	10	13	7	2	2	2	2	3
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Why they use it

The prevention section included a question on whether the interviewee was trying to prevent any specific disease or problem. Two participants answered no to this question (they were both in their mid-twenties). Two others said they were trying to prevent “all serious diseases,” but went on to enumerate specific ones. There was a range in responses to this question; six people were trying to prevent cancer, three said diabetes, three said heart disease, and four cited osteoporosis (see table 6). Two people specifically noted that eating fruits and vegetables help prevent cancer. Other answers were: headaches, weight gain, asthma, remission of an immune disorder, and degradation of current body state. These were more life-long or long-term goals.

Table 6. Illnesses attempting to be avoided through preventive treatments.

Illness	Cancer	Diabetes	Heart Disease	Osteoporosis	All serious diseases
Number of times cited	6	3	3	4	2

Symptom section of interview

The treatments

There were thirty-one possible symptoms that each interviewee could identify and discuss during the interview. Each symptom was discussed in terms of treatments used for each stage of the illness (pre-onset, onset, and further levels of severity), why this treatment was chosen, and how she learned about the treatment. These women talked about a wide variety of treatments that they used for different symptoms. Some CAM treatments were mentioned by many interviewees or were unusual; those will be mentioned to give the reader an idea of the extent and variety of treatments.

There was some congruency among CAM treatments chosen (see table 7). Fourteen women used tea for treatment, fourteen used vitamin C, and ten talked about drinking water or fluids. Half of those interviewed (8) gargled salt water for a sore throat, and seven ate soup when they were feeling sick. Other popular remedies were Echinacea, using ginger ale or ginger tea, zinc cough drops, taking a hot shower, using caffeine for headaches, and avoiding dairy products.

Table 7. CAM treatments used for symptom management and the number of women who cited each treatment.

CAM therapy (for various illnesses)	Number of women using therapy
Drink hot tea	14
Take vitamin C	14
Drink water or fluids	10

Gargle salt water	8
Eat soup	7
Use Echinacea and/or Goldenseal	6
Avoid dairy	6
Drink ginger tea or ginger ale	5
Use zinc	5
See chiropractor	5
Drink caffeine	3
Use glucosamine	2

It is important to note that there was a broad range of CAM therapies used, from what might be called “folk” remedies, to CAM therapist use, to commercially marketed CAM products (such as herbal remedies). Some of the things that these women reported using for various symptoms were: fresh fruit for constipation, chiropractic for back pain, massage for headaches, milk to calm down, magnets for pain, heat for pain, a day off for “mental health”, garlic for a cold, hot coffee cup against one’s head for a headache, Epsom salt baths for various symptoms, aromatherapy for sinus problems, and sleeping to relieve a symptom. Most women also mentioned waiting as part of their symptom treatment, to see if the problem would alleviate itself.

Treatment order in terms of health care sequence

The order in which CAM therapies were taken in the health care sequence is crucial to understanding their use and why people use them. Most therapies were taken as precursors to biomedical treatment. Only three women mentioned using CAM therapies as treatments after biomedical interventions, and these were specific cases where the therapy was ineffective, difficult to obtain, or caused bad side effects and left the problem untreated. This is, in part, due to the structure of the interview. The focus was on primary and secondary treatments, although there was a section that asked about particularly troublesome symptoms that may have caused the patient to seek all forms of possible care. As mentioned earlier, six women discussed having chronic or serious health problems. The results of this study show CAM use as a primary or preventative health measure. The positive characteristics of CAM identified by the participants are what make these therapies ideal for use in this manner. Later, in the ethnographic results section, these specific reasons for use will be explored. Perhaps a study that focused mainly on post-biomedical CAM use would get much different responses about the participants’ reason for use, but the reasons obtained here explain why CAM use may be so widespread.

Information sources for health care

Interviewees cited many different sources for their knowledge about preventive medicine; some cited more than one. The most common ways that people said they learned about what to do was from the way they were brought up (or their past); and from general life experiences. Eight people cited each of these reasons. Books and magazines were information sources for five women, friends or networks of people were resources for three, and one woman said her doctor informed her about preventive medicine. The most popular source of information about specific symptom treatments was the interviewee’s mother. Information about different therapies might be learned about

through different sources and combined to address all possible illnesses the interviewee might face; i.e. there was no single source for these women's health knowledge. Health professionals were the second most often cited as influential for symptom management. Friends and family members were next in influencing the respondent. Magazines, daily life experiences, and health food stores were also mentioned as sources for information about health treatment.

Areas limiting quality of interviewee's health care

In an effort to better understand influences that might be causing people to choose CAM for their health care, interviewees were asked what resource they thought would most improve their health care (see table 8). Time, money, and access to resources were given as broad categorical examples. Nine women chose time, eight said access to resources, only two said money was a limiting factor in their health care (each woman could cite as many as she liked).

Table 8. Resource most beneficial to improving health care.

Resource	time	money	Access to resources/information
Number of times cited	10	2	8

The two women who cited money as a barrier to health care were 26, so they were at the beginning of their careers and were probably in a more economically precarious position. Both also had special circumstances that made their health insurance less comprehensive than that of the other women. There were five women in this study who were thirty or younger, three of those did not cite money as their most needed resource. In addition, those that did cite money as a limiting factor were not characterized as using CAM to a different extent than others. As mentioned earlier, this study was constructed to limit the role of financial circumstances in health care choice making, so this aspect was fairly successful. There was an association, however, between citing time as a factor in one's health care use and the amount of CAM used (see table 9). Those who cited time as a limiting factor in their health treatment tended to use CAM therapies outside of "home remedies" more than those who did not cite time as a factor. In turn, the women citing this time deficiency also tended to have dependent children (see table 10). This association will be dealt with in greater depth later in this paper.

Table 9. The association between citing time as a factor in one's health treatment choice and types of CAM therapies used.

	Uses only "folk" therapies ("home remedies")	Uses CAM therapies outside of "folk" therapies
Cited a time deficiency	3	7
Did not cite a time deficiency	4	2

Table 10. The association between citing time as a factor in one's health treatment choice and having a family.

	Has a family	Does not have a family
Cited a time deficiency	7	3
Did not cite a time deficiency	1	5

The following quotes show specifically what women said about the constraints that complicate their health treatment.

- “Time to actually think about taking care of myself, and you know, one of the reasons that I seldom get sick, is because I can't get sick 'cause I have three kids and I can't get sick and you tell your body that you can't get sick or get better real quickly because you don't have time to be sick and so you do” (2001a).

- “I don't like that, within the health insurance plans that there are only certain doctors or certain places you can go. So I guess my ideal world is you get to choose your doctor or your hospital or whatever it is that works for you instead of having it in a book” (2001d).

- “It's hard to, for example, with this physical, I started in August setting this up with my doctor and it has to be first thing in the morning, so it has to be on a day on the week that I don't have class first thing in the morning, early first or second thing and the first two times I set this appointment up the office has called me and said that my doctor, the woman I really like is going to be out of the office.” “If I had one thing more in this world, it wouldn't be money, it would be time” (2001c).

- “I think it would be wonderful if my insurance covered massage therapy, which it doesn't” (2001b). “In general, we live in a incredibly stressful society, far more than when I was younger, and that, across the board, things that would reduce stress would be a smart move on the part of say, management in businesses and stuff who are looking to, number one: keep their employees healthy so they can keep working for them, and number two, keep their insurance costs down” (2001b).

The issues apparent from these quotes are that time and other factors limit the control these women have over their health treatment. The deficiency in time may be due to the complex role that most of these women play as both mothers and wage earners. It is evident that CAM use is more extensive among women who have families. The next section explores this correlation and the features of American life that has lead to this trend.

UNDERSTANDING CAM USE

As mentioned earlier, CAM use is widespread, the highest use present among the population chosen for this study. National studies show that CAM is used by as much as 42.1 percent of the population and is mainstream. It is used mainly by non-minority

women with some college education above the age of 30, with rates of CAM use higher in the West. Studies of CAM use in the South estimate that the rate of CAM use is even higher, from 44 to 62 percent of people having used CAM. Studies completed in the South also indicate that white women 30 years old and older with some college education are using CAM to the greatest degree. There have been several studies that have explored why people choose CAM (Astin 1998; Furnham and Beard 1995; Furnham and Smith 1988; Palinkas and Kabongo 2000; Pergola and Paschel 1998; Vincent and Furnham 1996). A few of these studies took the etic (or researcher's) perspective, characterizing CAM users as having certain beliefs or leanings towards certain perspectives on life such as being more liberal (Astin 1998; Furnham and Beard 1995; Furnham and Smith 1988). Other studies have associated this use with a desire to have greater control over one's health treatment (Palinkas and Kabongo 2000; Pergola and Paschel 1998; Vincent and Furnham 1996). The remaining study looked at these factors and associated them with societal trends, rather than just characteristics of the population using CAM. In addition, this study noted time deficiency as an aspect of these societal trends. The next section will explore the above-mentioned study, as a foundation for understanding the data from this study.

Pergola et al.

The Hartman Group, a firm that does research for marketing companies on natural products, completed this study in 1998 (Pergola and Paschel 1998). Twenty interviews were done in Boston, Chicago, Seattle and San Francisco, for a total of 80 one-hour interviews. Interviewees were screened by the market research firm in order to find people who use all levels of CAM (from a variety of age groups and both men and women). The study was attempting to avoid people who use CAM much more than the average consumer. The study population was almost entirely white. Interviews were free form, based on questions like "tell me about your use of CAM therapies" (referred to as integrative medicine in this report). In addition, questions like, "when did this start," "how often do you go to the store," and "when was the last time you took this therapy," were asked (Pergola and Paschel 1998). The results of this study were fascinating.

The researchers discovered that although consumers were using CAM, they were not using it consistently across all aspects of their lives (Pergola and Paschel 1998). For example, a person might use herbal supplements for weight loss, but not for any other purpose. Another example is seeing an acupuncturist for headaches, but using biomedical techniques for all other health problems. In addition, they found that one does not need to be a certain "type" of person to use CAM. This general use by people (of specific therapies) has resulted from what they see is a shift in ideology, stressing "wellness" and "natural sensibility" (Pergola and Paschel 1998). They associated this shift in ideology with three societal influences: a feeling of a compressed sense of time, increasing differentiation in CAM therapy options, and a feeling of loss of control over one's life.

TIME DEFICIENCY IN AMERICAN LIFE

Non-minority college-educated working women with families espouse the idea that they are experiencing a time deficiency and thus losing control over their life. CAM use is associated with a feeling of greater time deficiency, as is having a family. This

sense of time deficiency has been affected by the changing structure of American life and has thus influenced health care choices.

Control of time

As established earlier, ten out of sixteen of the women interviewed expressed that a lack of time was limiting their health care. In addition, those who acknowledged a feeling of time deficiency as a factor in their health care also were more likely to use CAM therapies outside of home remedies. In this study, the feeling of time deficiency was more pronounced among non-minority college-educated working women with families (defined as dependent children) than those without. As a result, this group tended to use more CAM therapies outside the folk sector. Out of the ten women who cited a time deficiency as a controlling factor in their health care, seven had families. Only one woman with a family did not discuss time deficiency as effecting her health care. The idea of a time deficiency is not uncommon among Americans (Jackson 2002). Although a feeling of time deficiency may be present without support of an actual deficiency of time, there is a definite trend in the United States among working women with families towards a reduction in time availability. This structural and mental time deficiency is compounded by aspects of biomedical care and draws non-minority college-educated working women with families towards CAM.

Women are the main health care providers in the family (Bull 2001), but they no longer have the sole role of caring for the family. They must also help support the family financially. The National Survey of Families and Households found in 1987 and 1988 that among dual-income families, even though the outside of the house work hours decreased for women after they had children, their total work hours increased from 60.4 mean hours per week to 99.4 mean hours per week. In comparison, men's work hours went from 60.1 to 79.7 mean hours per week (Sanchez and Thomson 1997). They showed that a couple works individually inside and outside the house for about 8 1/2 hours per day before children. After having children this work time expands to fourteen hours per day for women and eleven for men (Sanchez and Thomson 1997). In addition, it seems that this time deficiency, due to the dual role of the mother as an economic provider and a caregiver, is increasingly affecting more of the population. The percent of women employed full time, year-round, in the previous year between the ages of twenty-five and fifty-four increased 17.8 percent from 1978 to 1998 with an additional 413 hours of work on average per woman per year between those years (2000). Even in the unlikely event that these trends are not true for the women involved in this study, the psychological feeling of time deficiency is sufficient to affect change in their use of health care therapies. Women feel they have a diminishing amount of free time and this is causing them to feel less in control of their health care.

The reduction in time for mothers has meant a lot of things to the American family and in turn to their health care decisions. Increasingly, there is a trend for "outsourcing" of goods (Jackson 2002; Parcel 1999), paying for other people to provide services that are usually completed within the family. For example, getting "take-out" food instead of cooking, paying someone to walk one's dog, and hiring a cleaning person. In terms of medical care, less time at the family level has been compounded by less availability of professional biomedical treatment (Siahpush 1998). Unlike in the past, patients can no longer see the same doctor every time they are sick and go to whatever

pharmacy they want. One's health insurance often mandates which doctors one can see and requires many prescriptions be ordered from a specific company rather than picked up at the local pharmacist (Kronenfeld 2001). Attempting to find appropriate doctors and pharmacies that are covered by one's insurance plan, causes biomedical treatment to be tedious. Mothers, as the enduring providers of health care in the family, are looking for options that allow them more control over their time. CAM provides therapies that are more easily available. For example, one may consult with a health store employee or an alternative therapist. CAM therapies are generally less steeped in prestige and hegemony so they are more easily accessible to patients (Starr 1982). Alternative therapies are also not as expensive as conventional health treatments (Bennett and Lengacher 1999; Oumeish 1998). Although this was of little concern to the women interviewed, it would explain a lack of immediate concern for the therapy's coverage by health insurers (as most CAM therapies are not covered).

There are other factors that affect the use of CAM by these women. Women who did not cite time deficiencies or did not have dependent children were still using a certain level of CAM, mostly in the form of "home remedies." The reasons for this use were alluded to by Pergola et al. and others (Palinkas and Kabongo 2000; Pergola and Paschel 1998; Vincent and Furnham 1996). The extent of these influences will not be discussed in this paper. These influences are a factor of overall CAM use by the women in this study, but the idea of time deficiency explains the greater use of CAM by non-minority college-educated working women with families. Time deficiencies and the structure of biomedical care limit the independence and control of working mothers and thus are a concern for this group.

CONCLUSION

The women in this study saw control over time as central to their choice of health treatments. As American culture has developed in the late 20th and early 21st century there has been a shift towards roles for women that increasingly demand more of their time. As women have taken on greater responsibilities for work inside and outside the home, the construction of American life has been altered. Women seek better health care options for themselves and their family. These options are more time-efficient and allow a greater control over the time input needed for health care. CAM therapies fulfill these roles which directly contributes to the extensive use of CAM by non-minority college-educated working women with families. The nature of healing done by the family in the 21st century is characterized by greater CAM use and has been intimately shaped by societal changes in this country.

Table 1. Summary of studies on CAM use.

Study	Study size	Demographics of sample	Therapies included	Percentage of people using CAM therapies	Characteristics of highest CAM users
Eisenberg's 1990 study	1539	18 years old or older, English speakers with telephones, weighted on sociodemographic discrepancies to correspond to characteristics of national population	Relaxation techniques, herbal medicine, massage, chiropractic, spiritual healing by others, megavitamins, self-help group, imagery, commercial diet, folk remedies, lifestyle diet, energy healing, homeopathy, hypnosis, biofeedback, acupuncture	33.8	Non-African Americans, 35-49 year-olds, some college education, annual incomes above \$35000, living in the West
Eisenberg's 1997 study	2055	18 years old or older, English speakers with telephones, weighted on sociodemographic discrepancies to correspond to characteristics of national population	Relaxation techniques, herbal medicine, massage, chiropractic, spiritual healing by others, megavitamins, self-help group, imagery, commercial diet, folk remedies, lifestyle diet, energy healing, homeopathy, hypnosis, biofeedback, acupuncture	42.1	Women, non-African Americans, 35-49 year-olds, some college education, annual incomes above \$50000, living in the West
Paramore's study	3450	English and Spanish speakers weighted to represent the U.S. civilian, non-institutionalized population	Chiropractic, therapeutic massage, relaxation techniques, acupuncture	9.4	19 to 64 year olds, live in the West, poor health, no HMO or IPA plan
Druss and Rosenheck's study	16,068	18 years of age or older, Spanish or English speakers, nationally representative sample	Acupuncture; nutritional advice or lifestyle diet; massage therapy; herbal remedies purchased; biofeedback training; training or practice of meditation, imagery, or relaxation techniques; homeopathic treatment; spiritual healing or prayer; hypnosis; traditional medicine, such as Chinese, Ayurvedic,	6.5	Female, white, more educated, live in the west, poorer health

			American Indian, etc; and other complementary or alternative treatments		
Baussel et al.	16,038	18 years of age or older, Spanish or English speakers, adjusted to be representative of the US population	Chiropractic; massage therapy; herbal remedies; spiritual healing or prayer; nutritional advice; acupuncture; meditation, imagery, or relaxation; homeopathic treatment; traditional medicine; biofeedback training; hypnosis	9.0	Female, 30 to 59 years old, more educated, live in the West or mid-West, poorer health
Oldendick et al.	1,584	18 years of age or older, Spanish or English speakers, telephone owners, data were weighted to reflect the characteristics of the population of South Carolina on the basis of age, race, and sex	Personal therapies (including home remedies, herbal medicine, homeopathy, or vitamin therapy), relaxation techniques (including massage therapy, imagery, or visualization), chiropractors, healing (including healers, spiritual healing, Native American healers, or energy healing), commercial weight loss programs, life-style diets, self-help groups, hypnosis or biofeedback	44	Women, white, 30 years old and older, some college education, divorced or separated
Burg et al.	1,012	18 years of age or older, Spanish or English speakers, telephone owners, representative of the Floridians in terms of sex and race but over-representative of older age groups	Home remedies, special diet, relaxation techniques, herbal medicines, massage therapy, homeopathic medicines, acupuncture, biofeedback, energy healing, hypnosis	62	Female, white, 12 or more years of education, widowed or divorced, 36 years old and older

Endnotes

ⁱ. This type of medicine is also referred to as natural, non-biomedical, unorthodox, unconventional, fringe, complementary, and so on. These therapies are best encompassed by the terms complementary and alternative medicine (CAM), which will be used throughout this paper. Although the differences are not often acknowledged, “alternative” medicine refers to medical practices that are used in place of conventional western care. Complementary therapies are those therapies that are not within the realm of conventional care but are used in conjunction with conventional care 2001e

National Center for Complementary and Alternative Medicine, Vol. 2002:
National Institutes of Health. The broad spectrum of terms which are often used interchangeably or to indicate different therapies by different people, make it difficult to come to one solid definition of CAM. Without getting too deeply into those complexities, the National Institutes of Health defines CAM as, “those treatments and health care practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies” 2001e

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National Institutes of Health..

ⁱⁱ. This population may seem small, but is appropriate for the ethnographic format of this research. The limitations that are posed by such a sample have been considered and will be addressed in this paper.

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