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# Identity in a medicine cabinet: Discursive positions of Andean migrants towards their use of herbal remedies in the United Kingdom

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ABSTRACT

This study explores different rationales for using herbal remedies among people from Andean descent in the United Kingdom, using positioning theory as a conceptual framework. By analysing processes of positioning in narratives about healthcare choices conducted with 40 Bolivian and Peruvian migrants in London (between 2005 and 2009), we examine in which ways talking about personal preferences for herbal medicine can be constitutive of one's health identity. The results reveal three distinct discursive repertoires that frame the use of herbal remedies either as a tradition, a health-conscious consumer choice, or as a coping strategy, each allowing specific health identity outcomes. An enhanced understanding of how people make sense of their use of traditional, plant-based medicines enables healthcare professionals to better assist patients in making meaningful decisions about their health. Through illustrating how treatment choices are discursively linked with identity, the present results debunk the tendency to perceive patients with a migration background as one homogenous group and thus urge for a patient centred approach.



## 1. Introduction

The use of herbal remedies -i.e. plant-based medicinal preparations-is a common healthcare seeking strategy among diverse migrant communities in western urban areas (Pieroni and Vandebroek, 2007; Muniz de Medeiros et al., 2012; Vandebroek and Balick, 2012; Quave et al., 2012; Pieroni and Privitera, 2014). Likewise, people from Andean descent who live in the United Kingdom continue to use a wide variety of herbal and natural remedies known from their country of origin, especially for minor ailments and preventive care (Ceuterick et al., 2011), although no statistically representative data exist.

Health choices are often identity-infused habits (Oyserman et al., 2007). Like dietary choices, consuming herbal remedies can be a conscious action that contributes reflexively to a sense-of-self (Fox and Ward, 2008a). The choice for one or multiple treatment options within pluralistic healthcare systems reflects degrees of negotiation among different forces, including financial and physical access, availability of healthcare, gravity of illness, knowledge of home treatments, cultural beliefs about health, perceived effectiveness, faith in a certain treatment, but also the expression of identity (Young and Young-Garro, 1982; Miles and Leatherman, 2003; Ceuterick et al., 2007; de Pribyl, 2013).

For migrants, multiple medical realities exist, ranging from traditional over complementary and alternative to biomedical healthcare facilities in different locations. Traditional medicine is based on health related knowledge indigenous to a certain culture; complementary and alternative medicine includes treatments that fall outside of mainstream biomedical healthcare (WHO, 2000). As such, diverse pre- and post-migratory bodies of health knowledge form a wide variety of treatment options. Besides the use of herbal home remedies, a range of alternative healthcare seeking strategies has been documented among Latin-American communities in London, such as informal care from unregulated alternative providers (naturopaths), private healthcare from Spanish-speaking doctors, self-medication with over-the-counter or imported pharmaceuticals and transnational biomedical care (accessed during visits to the country of origin) (McIlwaine et al., 2011; Gideon, 2013). In a migration context, the use of traditional herbal medicine can be a deliberate strategy to strengthen and affirm an ethnic

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identity (Gervais and Jovchelovitch, 1998; Pieroni and Vandebroek, 2007; Jeffery and Rotter, 2016). Herbal remedies can be subtle symbolic vehicles for different forms of identity, including social, ethnic, or class identity (Crandon-Malamud, 1983; van der Geest and Reynolds Whyte, 1989). When seeking healthcare, people produce and reproduce narratives that act as metaphors for their position in the social world (Gold and Clapp, 2011). As such, medication narratives (accounts of medication use) are useful tools in illuminating one's identity (Bissell et al., 2007).

In this article, we borrow the concept of health identities that emerge from health related practices (Fox and Ward, 2006, 2008b). Specific aspects of embodiment, such as the consumption of herbal medicine, are embedded in a web of associations from which health identities are constructed (Fox and Ward, 2008b). Health identities are emergent identifications that are created actively, in relation to available discourses (Davies and Harré, 1990). Health identities are not static, and can be equally congruent with both medicalised conceptions of health and illness, and resistance to biomedicine (Fox and Ward, 2006).

Generally, patients are not prone to spontaneously disclose non-biomedical uses to health professionals (Stevenson et al., 2003; Howell et al., 2006; Vickers et al., 2006; Chao et al., 2008; Shelley et al., 2009; Posadzki et al., 2013). Most practitioners in the United Kingdom only occasionally ask about the use of herbal medicine when planning or reviewing a patient's drug therapy (Thomas and Coleman, 2004; DTB, 2010), despite an average prevalence rate of herbal medicine use of 37% (Posadzki et al., 2013). This lack of communication has potential negative outcomes, such as an interference with proper utilization of biomedical care, non-adherence to prescribed biomedical treatments, or undesired interactions between different types of medicines (Stevenson et al., 2003; Vandebroek, 2013). As such, awareness about patients' treatment preferences can help to improve healthcare delivery. Knowing why and in which circumstances people choose to rely on herbal remedies can improve the quality of care and advise policies aimed at enhancing patient safety and patient centred care.

This article uses a discourse analysis to understand the choice for herbal medicine, and the meaning of those remedies in Andean people's lives in London. In health research, discourse analysis is commonly employed to examine how language is used to create and enact identities and health activities (Lupton, 1992; Starks and Brown Trinidad, 2007). By focusing on medication and healthcare-seeking narratives, we describe the symbolic associations of herbal medicines in people's lives and the role these remedies play in shaping health identities. Using positioning theory, we explain how people originating from Andean countries position themselves with respect to their use of herbal remedies, and what underlying identity needs these choices represent. The two central questions that this article seeks to address are: (1) *How do Andean migrants explain their use of herbal remedies in the United Kingdom?* and (2) *How is language about their preference for herbal remedies used to discursively construct identity?*

## 2. Materials and methods

### 2.1. Theoretical framework

Positioning theory assumes that identities emerge through social interaction and are reflexively (re)constituted in discursive practices and narratives (Davies and Harré, 1990; Benwell and Stokoe, 2006). Following these theoretical assumptions, identity is defined as a subject position in relation to social representations -condensed in interpretative repertoires-as people make sense of themselves and their actions by drawing on and reconstructing those social representations (Fox and Ward, 2006; Andreouli, 2010). A subject position is both who the speaker is to be seen by others, and the perspective from which (s/)he sees the world. To construct a subject position or identity, people draw on, resist, or (re)negotiate interpretative repertoires (Davies and Harré, 1990; Charlebois, 2008). A socially defined interpretative repertoire is a patterned and recognisable routine of descriptions, arguments and evaluations that can be distinguished by recurrent themes, metaphors and characterisations (Wetherell, 1998). Interpretative repertoires are culturally familiar, habitual lines of argumentation, from which accusations or justifications can be launched, without having to spell out an entire argumentation. Apart from adopting positions, speakers also assign certain positions to other people, including the interviewer and non-present others (Charlebois, 2008). Interpretative repertoires can be used to construct positions for one's self, and for others. Hence, the notion of positioning clarifies the relational, dynamic and contextual character of identity. Interviews provide an ideal arena for discursive practices, and for participants to draw on discursive resources (Potter, 2004).

### 2.2. Data collection

A total of 40 in-depth, semi-structured interviews were conducted between 2005 and 2009, with equal numbers of Peruvian and Bolivian migrants in London, as part of a larger study on the use and perception of traditional medicine among Latin-American migrants in the United Kingdom (Leverhulme Research Project Grant F00235D, PI: Andrea Pieroni). This study was granted ethical approval by the University of Bradford Ethics Committee. Data saturation (based on knowledge and preference of herbal remedies) occurred after approximately 12–15 interviews in each group. Participants were recruited through purposive sampling (Tongco, 2007). Prior consent was obtained verbally before each interview. Interviews lasted between one and three hours, were conducted in Spanish by the first author, recorded and then fully transcribed in a cut-down form of Silverman's guidelines (2001). Relevant quotes were translated into English afterwards.

Table 1 shows that participants had been living in the United Kingdom between one and 30 years. All Peruvian interviewees originated from the capital, Lima, except for one person from Arequipa. All Bolivians previously lived in the city of Cochabamba. Although a third had also lived in La Paz and/or Santa Cruz reflecting internal mobility before migrating abroad. Slightly more women were interviewed (ratio 23:17). Participants differed in age between 19 and 75 years. To the best of our knowledge, none of them had obtained British citizenship through nationalisation. The majority of interviewees claimed to have migrated to pursue better economic circumstances. One third of the interviewees worked in the cleaning industry. Forty percent of all participants held master degrees from institutions in their countries of origin (in medicine, dentistry, nursing, veterinary medicine, law, engineering and economics) and were over-qualified for their jobs in the United Kingdom. The remaining participants did not specify their educational background. A minority of 15% held positions that matched their educational background. Usually they had been living in the United Kingdom for longer, or they had initial long-term perspectives to stay in the United Kingdom (because of work, marriage or family reunification). Three people were unemployed at the time of the interview. Two were studying. One woman identified as a fulltime housewife. Four persons were retired. Other demographics are set out in Table 1. Participants who did not confirm registration with a general practitioner, were either unsure or claimed they planned on registering or did not provide an answer to the question. Such ambiguous answers could be related to taboos on legal status.