

Challenging perspectives: women, complementary and alternative medicine, and social change

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Abstract

This article presents an analytical review of literature that examines women's practice and use of complementary and alternative medicine (CAM). To interrogate this body of literature, I draw on new social movement scholarship and a feminist understanding of the notion of "the personal is political". Although women's prominence in CAM is consistently noted, our understanding of the relationship between CAM and gender remains underdeveloped and our knowledge about the role of CAM in social change processes is limited. My focus is therefore on the interplay between women's practice and use of CAM, personal transformation and social change. This exploration demonstrates that women's practice and use of CAM presents an opportunity to fulfill and confront traditional gender roles and dominant discourses of femininity. Furthermore, I illustrate that women's practice and use of CAM contributes towards promoting and achieving social change through the changing of the customary social practices of biomedicine, the development of new epistemic paradigms, the shaping of new working practices, and the creation of alternative communities. In conclusion, I suggest that when gender constitutes an integral part of analysis and theorising, combined with a broader understanding of 'the political', new insights and perspectives on women and CAM emerge. These also further our understanding of health social movements.

Introduction

Background

The use of therapies designated as complementary and alternative medicine (CAM) in Europe, Australia and North America is well established (Harris and Rees, 2000), and the popularity of CAM is linked with a wide range of factors, including disappointment with biomedical healthcare and the rise of chronic health complaints, dissatisfaction with the doctor-patient relationship, post-modern values, and personal world views (Astin, 2000; Bakx, 1991; Furnham and Vincent, 2000; Kelner, 2000; McGuire 1988; Schneirov and Gezcik, 2003). Some social theorists associate the growth of CAM with patterns of consumerism and life style choices (Coward, 1989; Giddens, 1991) and have characterised it as "narcissistic self-absorption that reflects the anxieties of an increasingly atomized society" (MacNevin 2003: 22). Others view it as masking and perpetuating wider social inequalities (Berliner and Salmon 1980; Coward, 1989). Berliner and Salmon (1980), for instance, argue that CAM practices

commodify the personal problems and alienation experienced by individuals in western cultures by helping individuals to adjust to society while disregarding existing social relations from which much disease originates. Indeed, Coward maintains that CAM constitutes "the perfect solution of a personal politics of the body with a peaceful co-existence within existing economic structures" (Coward, 1989: 204). Similarly, Baer (2004) argues that CAM practices are a form of holistic health that excludes any recognition of social and economic determinants in the creation and maintenance of health.

Against this roughly sketched background, and while carrying out research on CAM, I asked myself: Can we assume that such practices primarily maintain a societal status quo and reproduce a culture of individualism without collective impacts? In my own research, the prominent picture of CAM as maintaining a societal status quo was continuously challenged. Women CAM practitioners repeatedly stressed their intention to facilitate personal and social change through CAM and their patients told of the profound changes produced through their use of CAM. Here I was on familiar ground: a feminist, I had practised an alternative therapy for many years and had heard many stories by women patients of how their use of CAM supported them to think and feel differently about themselves and how this enabled them to make extensive changes in their lives. Despite the familiar ground, I was also puzzled. The majority of my research participants did not identify themselves as feminists, so would not have, I assumed, the same or similar commitments to producing social change as myself.

Together, these experiences, thoughts and challenges prompted me to search for ways of thinking and exploring women's practice and use of CAM that would reflect the practices and experiences of women in CAM more closely than presented so dominantly in much of the literature. As part of this endeavour, I engaged with new social movement (NSM) theories, which argue that by redefining the body, health and illness CAM promotes cultural innovation and social change that reflects individuals' needs for freedom, expression and creativity (Melucci, 1989, 1996a/b; Stambolovic, 1996). I also re-read the literature on the practice and use of CAM, searching out specifically studies on women's practice and use of CAM. Reading "across" the papers with a focus on gender and NSM theories in mind, a number of shared key themes emerged from this body of literature. This enabled me to see a picture of women's practice and use of CAM which differs from the prominent presentations sketched above in important ways. These themes and ideas are presented in this article.

The aim of this article is two-fold: First, by focusing on women's practice and use of CAM, I want to examine the interplay between CAM, women and change processes, and second, I want to invite a broader perspective on understanding CAM than is currently prominent in much of the sociological and anthropological literature on CAM. On the basis of the literature reviewed, I suggest that women's practice and use of CAM presents an opportunity to fulfill

and confront traditional gender roles and dominant discourses of femininity.¹ I further argue that women's activities in the field of CAM promote social and cultural change in healthcare and beyond and contribute to a broader "culture of challenge" (Scambler and Kelleher, 2006). Accordingly, women's practice and use of CAM forms, I suggest, part of other health social movements that create new healthcare practices and norms and propose new paradigms of knowledge.

To support my assertions, I weave together three strands of literature on women's practice and use of CAM. These are presented in three sections. In the first section, I examine historical and ideological overlaps between women's health and women's alternative health movements. In the second section, I focus on the clinical encounter between women practitioners and women patients, and examine the related issues of empowerment, control and responsibility in CAM. These two sections reflect some of the feminist critiques of biomedical healthcare and I examine how these critiques are addressed and play out in women's practice and use of CAM.

The third section examines why women, more than men, are attracted to CAM, and I then explore the ways in which women's practice and use of CAM produces, as I suggest, personal transformation. Here, I focus on the socio-cultural consequences for women of their practice and use of CAM and engage with key aspects of Melucci's (1989; 1996a/b) new social movement theory. In so doing, I do not review literature that examines clinical outcomes or assesses whether CAM or an individual CAM therapy "works" or how it works for particular physical complaints or diseases. In a fourth and final section, I draw out the implications of CAM for wider social change. To this end, I interrogate how the multiple personal change processes I have identified as being generated and/or visible in women's practice and use of CAM lead to and sustain social change beyond the lives and experiences of individuals. This section again draws on Melucci's (1989; 1996a/b) new social movement theory, particularly on how he conceptualises social change processes.

The challenges of CAM research

Several challenges arise when exploring CAM. A central difficulty is the absence of an agreed understanding of CAM. The modalities commonly designated as CAM represent a diverse spectrum of epistemologies and practices, ranging from the more mainstream (such as osteopathy, acupuncture or reflexology) to the esoteric (such as spiritual healing). This highlights that "CAM" is a heterogeneous category and CAM therapies are difficult to categorise. Many different definitions of CAM have been put forward, including the following: CAM are those therapies not included in biomedical healthcare provision²; CAM

¹ In understanding femininity I follow Young (2005: 31) to refer to "a set of structures and conditions that delimit the typical *situation* of being a woman in a particular society, as well as the typical way in which this situation is lived by the women themselves."

² <http://nccam.nih.gov/health/whatisacam/>

as diagnosis, treatment and/or prevention which complements biomedicine (Ernst, 2000). Attempts have also been made to categorise CAM therapies according to available evidence that supports its effectiveness and safety, and also levels of professionalisation (House of Lords, 2000).³ These definitions and categorisations are highly political since they are underpinned by notions of legitimacy of different CAM therapies, from the perspective of biomedicine and legislators.

The shifting of definitional boundaries over time and across different locations exacerbates the difficulties associated with defining CAM. Many different local terms for CAM are in circulation, including (to name but a few) *sanfte Medizin* or *medicines douces* (gentle medicine/s) in German and French (respectively), *alternativ behandling* (alternative treatment) in Denmark, *medicines non-convenzionali* (non-conventional medicine) in Italy, or *medicina natural* (natural medicine) in some Spanish speaking countries. The diversity of terms and healing practices included under the term CAM thus indicates that the 'need' or interest in an umbrella term derives less from CAM practitioners or users but rather from legislators interested in the regulation of CAM therapies, and/or researchers who examine CAM as a social phenomenon (Baer 2004). Wherever possible, I identify local contexts and the specific CAM therapy discussed; otherwise, I use the generic CAM as used in most sociological literature. The majority of studies drawn on in this article explore CAM therapies outside of biomedical provision.

An additional difficulty is that the literature on CAM is highly undifferentiated and unspecific concerning CAM users and practitioners. Although women users and practitioners, like their male counterparts, are far from homogenous, there is a tendency to refer to a generic "user" or "practitioner" without further demographic detail (for an exception, see e.g. Upchurch and Chyu, 2005). In addition, little is known about how, in the CAM context, gender intersects with other social differences such as class or ethnicity, and how gender issues and any intersections might change over time in specific socio-cultural contexts and/or in relation to individual CAM therapies (for an exception, see e.g. Baer, 2001). It is through using the category of gender and by focusing on women's practice and use of CAM that different perspectives and new insights emerge. In this way, I hope to contribute to more nuanced explorations of these important issues.

What do we know about CAM users and practitioners?

A number of studies have established how many and what types of people use CAM therapies (Astin 2000; Eisenberg, Kessler et al. 1993; Eisenberg, Davis et al. 1998; Kelner and Wellman 1997; Thomas, Nicholl et al. 2001; Upchurch and Chyu 2005; Vickers 1994). Consistently, these studies find: a predominance of

³ <http://www.publications.parliament.uk/pa/ld199900/ldselect/ldsctech/123/12303.htm#a2>

women users; users who are in higher income groups; the middle-aged; and those with higher educational levels (Wootton and Sparber 2001). Initial use frequently aims to address chronic, painful and non-life-threatening illness which biomedical treatment had failed to resolve (Cant and Sharma 1999; Furnham and Vincent 2000; Kelner and Wellman 1997), though reasons for continuing CAM use may differ from initial motivations (Little 2009). A majority of users combine the use of CAM with biomedicine (Kelner and Wellman 1997; Sharma 1992; Thomas, Nicholls et al 2001). In the US, people's commitment to environmentalism, feminism and interest in spirituality and personal growth in particular are identified as strong indicators for the use of CAM (Astin, 2000).

Limited information is available about CAM practitioners, though women practitioners are said to outnumber male practitioners (Cant and Sharma 1994) and ratios vary with healing modality (Baer 2001; Cant and Sharma 1994). Indications are that those therapies with full-time training and a science-orientated curriculum, such as chiropractic and osteopathy, draw significant numbers of male practitioners, compared to "talking" therapies like naturopathy, homeopathy and Western herbal medicine which are practised by more women than men (Andrews 2003; Baer 2001; Nissen 2010). In the UK, 66% of chiropractors were men (in 1994), and in Canada 90% of the profession are men (Cant and Sharma 1999: 75). By contrast, in 2005 approximately 80% of registered Western herbal medicine practitioners were women (Nissen 2010).

More research is however needed that examines who CAM users and practitioners are in greater detail, taking a range of social differences into consideration as well as variations across different countries.

Shared roots: women's health and women's alternative health movements

Women's health and women's alternative health movements share a history, ideology and practices that challenged biomedicine's knowledge base and aimed at the democratisation of healthcare. Underpinning this is a critique of the legitimacy and power of the biomedical expert over women's bodies and women's lives that focuses on the nature of knowledge production and the meanings of different knowledges about the body (Kuhlmann 2009; Phillips and Rakusen, 1978; Ruzek, 1978; Weisman, 1998). These issues are explored in this section. Of particular interest here is the overlap between the two movements, for example around their commitments to recognise women as individuals with unique lives and experiences.

The women's health literature that emerged from the 1970s increasingly emphasised the need to prioritise women's self-knowledge and experiences. Women's personal knowing of their bodies and their experiences of health services shaped the critique of patriarchal biomedical practices, knowledge and authority, and highlighted the medicalisation of women's bodies and lives (Kuhlmann 2009; Oakley, 1980; Phillips and Rakusen, 1978; Ruzek, 1978). The

role and power of the biomedical expert in understanding women's bodies and determining healthcare was frequently noted. Power relations in (bio)medicine were seen to disregard women's subjective experiences and contribute to entrenching gender, class and racial inequalities (Doyal, 1995), leading to the counter-assertion that women must define their own experience.

Feminist reconceptualisations of women's health and healthcare foreground the centrality of women's bodies in women's oppression, and serve to examine how health is influenced and constructed by social and material circumstances and how experiences are shaped by institutions, practices, discourses, technologies and ideologies. Contextualising health within the lives and experiences of individuals and foregrounding both the diversity of women's experience and the interdependence of women's health on local and global communities became integral commitments of feminist health activists and scholars alike (Davis, 2007; Doyal, 1995; Kuhlmann 2009; Lagro-Janssen, 2007; Ruzek, Olesen, and Clarke, 1997).

While the women's health movement was challenging biomedicine's knowledge base and campaigning to transform the ideology, organisation and delivery of healthcare, women's alternative health movements also emerged (Ruzek, 1978; Weisman, 1998). A number of overlaps between women's health movements and women's alternative health movements can be noted, particularly the central commitment to identify and address women's health needs within the context of women's unique lives and experiences. In addition, women's alternative health movements often invoked three distinct and interrelated elements in their critique of biomedicine: women's history and their historical work as healers; women's distinct knowledges and ways of knowing; and nature (Bix, 2004; Feldberg, 2004).

Historical accounts of women as traditional healers added a particular perspective to understanding women's (alternative) health movements. Explorations of the rise and fall of women's healing traditions (Bourdillon, 1988; Ehrenreich and English, 1976) became central to efforts of women's health movements and alternative women practitioners to situate political action and critique biomedicine (Feldberg, 2004). The affirmation of the historical base for women's healing offered a powerful counter-ideology to biomedicine and unified the two movements in their approach to knowledge and healing practices (Bix, 2004; Feldberg, 2004).

Like the women's health movements, women's alternative health movements stressed women's distinct knowledges and personal ways of knowing about the body, providing a challenge to the knowledge base of biomedicine, predicated on women's unique and special wisdom (Feldberg, 2004). Self-help, central to many forms of alternative healthcare, further promoted the centrality of subjective knowledge and suggested that individuals could heal themselves (Feldberg, 2004). This mirrored feminist critiques of biomedical authority and expert knowledge.

Women's alternative health movements also laid claim to providing a fundamentally different kind of care that did more than cure – it healed (Feldberg, 2004). Adopting a “narrative of care”, women's alternative healthcare “relied on gentle products of nature [and] women's connection with the earth and its people” (Feldberg, 2004: 188). Practitioners of natural childbirth and herbal medicine in particular blended feminist interpretations of medical history with natural and spiritual principles, defining their practices as recovering their foremothers' legacies (Stapleton, 1994). In this way, alternative healthcare aimed to integrate women's personal needs with social and environmental commitments, enabling women to reconcile political action with social and spiritual change (Bix, 2004; Feldberg, 2004).

From the 1960s and 1970s up to the present, and as CAM has become a socially accepted phenomenon, it has undergone significant changes. These changes and moves have led to an apparent loss of CAM's “critical edge” as it becomes increasingly male dominated through ongoing institutionalisation and commercialisation (Schneirov, 2003) and the professionalisation and co-option of CAM into biomedical healthcare provision (Flesch, 2007). While much scholarly attention has been paid to explore these processes, women's everyday CAM practices have become increasingly submerged and invisible. This is not to suggest that developments related to the normalisation of CAM are unimportant, or that women are not involved in them (see e.g. Lee Treweek 2010) only that they present one particular perspective. By contrast, I suggest that much of women's practice and use of CAM, as presented in the literature examined here, retains a distinct character where the early critical values and attitudes to social practices (such as considering patients as individuals and the principle of egalitarian relationships) and towards social norms and expectations (for example gender roles or ecological sustainability) continue to be deeply embedded, even though they may not be connected to explicitly feminist commitments.

Women's practice and use of CAM: the clinical encounter and issues of power

The practice of medicine has been identified by feminist health activists and scholars, as well as others, as a site for the production and maintenance of social power. It has been argued that in most biomedical healthcare practices the ill person is transformed into a non-contextualised, diseased body, underpinned by the biomedical classification of reported symptoms as “subjective” and observed clinical signs as “objective” (Foucault 2003). This classification is said to lead to the disregard of patients' experiences, for example in the patient-doctor communication (Fisher 1988). Accordingly, throughout the literature on women's health many call for the need to listen to and prioritise women's self-knowledge and experiences. Indeed, some scholars argue that the growth of CAM reflects dissatisfaction with the doctor-patient encounter, particularly by women, and has led to a turn towards CAM which is said to be underpinned by more participatory practitioner-patient relationships than biomedicine (Bakx,

1991; R. C. Taylor, 1984; Kelner, 2000). How the CAM clinical encounter is described and experienced by CAM practitioners and patients, and how issues of empowerment and control play out by women practitioners and users are therefore the focus of this section.

Women working in partnership: the CAM practitioner-patient relationship

CAM practice is said to support a “partnership” model of interaction whereby patients typically collaborate with their practitioner, taking an active role in the healing process (Kelner, 2000; Sharma, 1994). Mitchell and Cormack (1998) suggest that a partnership in CAM should lead to healthcare that is negotiated and agreed between practitioner and patient. Furthermore, to individualise treatments, many CAM practitioners require diverse information from each patient regarding diet, lifestyle, social and personal relationships (Johannessen, 1996; Nissen, 2008; Scott, 1998; Sharma, 1992, 1994). In this way, patients are respected as experts and active partners and their health and needs contextualised within their lives.

A number of studies on women and CAM instantiate this general conceptualisation of the CAM practitioner-patient relationship. Barry (2003), for example, in exploring how UK women homeopaths and women patients share personal and professional knowledges in homeopathic consultations, concludes that the process of sharing knowledge contributes to an egalitarian relationship, while also directly altering women’s views of health, the body and illness. Her conclusions are supported by other UK studies of women’s use and practice of homeopathy (Scott, 1998), a variety of CAM therapies (Sointu, 2006b) and Western herbal medicine (Nissen, 2008). These studies demonstrate the importance to women patients of being listened to, having more time than in biomedical consultations, and the emotional support being offered by women practitioners.

For instance, Barry’s (2003) and Nissen’s (2008) ethnographic studies illustrate how women bring a tradition of “woman talk” (Devault, 1990) and other stereotypically female values such as empathy to their interaction, where women’s experiences are contextualised, and health and illness are explored within networks of relationships and responsibilities that characterise women’s lives (Lagro-Janssen, 2007; Ruzek, Clarke, and Olesen, 1997). In this emphasis on everyday lives, shared experiences, and relational values and practices, these homeopaths and herbalists challenge biomedical practices and knowledge production while reinforcing egalitarian relationships. According to Sointu (2006b) “recognition” offers the key to understanding women practitioner-patient relationships in CAM.

[D]ifferent levels of recognition that pertain to affirming the self, as well as to legitimizing identities and complaints, often come together to endow the client with a sense of empowerment and control. (Sointu, 2006b: 507)

In general, CAM practitioner-patient interactions tend to be perceived as devoid of tension and little is known about how differences of opinion between practitioners and patients are managed, such as those identified by Frank (2002) around the duration and cost of consultations by German homeopathic physicians. An exception is Nissen's (2008) study which demonstrates the centrality of narrative strategies in ongoing herbalist-patient negotiations and the contestations of unfolding stories. Narrative strategies are used by women herbalists and women patients alike, it is argued, to forge a "partnership of healing" that facilitates knowledge sharing and the building of consensus, but also accommodates differences and disagreements about how to approach and understand health problems.

The above studies point towards practitioners' commitment to egalitarian relationships. This suggests practitioners' willingness to relinquish a degree of control and the recognition of patients' authority which potentially lessening power asymmetries and becomes a key element in patients' empowerment.

Multiple tensions: women's empowerment through CAM?

Empowerment is a frequent theme in healthcare, including in CAM. The idea of empowerment is grounded in the "social action" ideology of the 1960s and the self-help movement of the 1970s, though notions of empowerment are complex and often lack clear definition (C. H. Gibson, 1991; Rissel, 1994). In healthcare, empowerment is understood as a collaborative process associated with the ideal of patient involvement in decision-making (Hewitt-Taylor, 2004; Jacob, 1996). To achieve shared decision-making, two bodies of knowledge need to be reconciled: medical knowledge and patient's subjective knowledge. This contrasts with an approach to healthcare based on the concept of power as expert knowledge (Fisher 1988; Ruzek 1978). Tensions however arise if empowerment is understood predominantly as the promotion of healthier "lifestyles", disregarding the fact that health is socially determined and contextualised (C. H. Gibson, 1991; Nettleton, 1996). These tensions around empowerment and control are also reflected in studies of women's practice and use of CAM.

In an Australian study of women users' perceptions of diverse CAMs used during the menopause empowerment constitutes a central concept (Gollschewski, Kitto, Anderson, and Lyons-Wall, 2008). The authors define empowerment as having the knowledge, skills, attitudes and self-awareness necessary to influence one's own behaviour. Central to this is women's need to be informed. Knowledge in turn facilitates women's informed choices and self-management of their symptom experience. This resonates with how some women herbalists envision healing with Western herbal medicine in the UK (Nissen, 2008). The key to healing, according to one practitioner, is "education and empowerment" (Nissen 2008: 208). In their relationships with patients, these herbalists employ a concept of power as the "power to empower" (Candib,

1994). This has implications beyond the practitioner-patient relationship and women's healthcare.

Women users in Barry's (2003) UK study of homeopathy and Nissen's (2008) UK study of Western herbal medicine note the importance of increasing self-care and self-knowledge as the basis for initiating changes in their personal, social and professional lives, using their emerging sense of power to create new identities for themselves as women. The importance of identity work undertaken by women engaging in natural health practices is also emphasised by Thompson (2003) who suggests that CAM's therapeutic ideology enabled his women participants to contest the implications of their biomedical diagnosis and to reconstruct their chronic illnesses as an opportunity for discovering their inner potential (see also Sointu 2006b).

These very different studies point towards the importance of women's empowerment through their use of CAM, whether this relates to women making informed choices and being more in control of their healthcare decisions, or to women's increasing self-knowledge and opportunities for identity work. Some writers, however, remind us that individual empowerment should not be confused with economic or "real political power" (Kitzinger, 1993). Others assert that while empowerment will not create social change in itself, strategies of empowerment offer "the potential to initiate [...] the possibility for social change through relationships that engage, transform and empower" (Candib, 1994: 153). In addition, some feminist scholars argue that when women improve the ways they manage their health, more autonomy in healthcare is experienced. As Ruzek (1996: 126) points out: "The fact that women can modify their behaviour [...] mean that women can exert some control over their own lives." These tensions highlight different perspectives on empowerment, all of which are valid and important to consider. Overall however, a focus on individual empowerment at the expense of societal factors is not specific to alternative health but is a frequent tension in healthcare generally (Gibson 1991; Jacob 1996; Christensen and Hewitt-Taylor 2006).

The thorny issue of "responsibility": practitioner and user perspectives

Individuals' expectations about their role in healthcare are predicated on being proactive, empowered and responsible in seeking healthcare (Baarts and Pedersen, 2009; Hughes, 2004). These expectations link with broader societal trends in which active involvement in healthcare reflects health policy developments and constitutes part of the ongoing engagement with processes of identity construction (Hughes, 2004; Sointu, 2006c). Others have argued that they relate to a distinct governing of subjectivity (Rose, 1990) or a new health consciousness and increasing "healthism" through the modification of lifestyles (Crawford 1980). CAM in particular has been charged with increasing narcissistic individualism and the promotion of a your-own-fault dogma (Coward, 1989; MacNevin 2003). Empirical studies of these issues in the

context of CAM however present a more nuanced picture. In the following, I first explore the perspectives of CAM practitioners, and then turn to CAM users' perspectives.

McClellan (2005) in his study of crystal and spiritual healing in England examines practitioners' discourses of blame and responsibility. These discourses, he suggests, are a central component of the healers' ideology, alongside an individualistic approach to health and illness. The healers' focus on the individual in explanations of health is interpreted less as being a result of a socio-political climate of "victim-blaming" but rather a manifestation of the need to redress the denial of the individual and subjectivity in biomedicine (McClellan, 2005: 630). The twin ideologies of blame and responsibility, McClellan (*ibid*) argues, are located in the wider context of socio-cultural transformations characterised by shifts to postmodernity or "late modernity".

Tensions between blame and responsibility are heightened when a discrete physical disease is transformed into a problem involving all areas of a person's life (Sered and Agigian, 2008). Sered and Agigian (2008) describe CAM practitioners' etiological frameworks for breast cancer as a discursively constructed "holistic sickening" and suggest that it underpins the meaning of holistic healing characteristic of CAM. While CAM counteracts the perceived depersonalisation of biomedical treatment, the therapeutic promise thus constructed can imply open-ended, albeit individualised, healing processes. Nevertheless, the "if it works for you" approach of CAM healing also serves to enhance a sense of agency and control among CAM users (McClellan, 2005).

Indeed, women CAM users stress opportunities for personal control and responsibility for their health as an important reason for seeking or continuing CAM healthcare. Women associate personal control in healthcare with the belief "that it is good to be able to sort things out for yourself", "the desire to have ownership and control over [...] experiences and treatments used" (Gollschewski, et al., 2008: 156) and "not to be told what to do" (Vickers, Jolly, and Greenfield, 2006). Hence women emphasise their active participation in treatment and care as central to their healthcare choices. This resonates with findings that initial CAM use is frequently prompted by chronic and painful illness that biomedical treatment failed to resolve (Kelner and Wellman, 1997), leading to a search for more effective healthcare and, once identified, its ongoing use (Baarts and Pedersen, 2009; Little, 2009).

An understanding of empowerment as women's control and agency emerges that is grounded in resisting biomedical constructions of disease and patienthood (Thompson 2003) and "a fresh and sustained sense of bodily responsibility that induces new health practices" (Baarts and Pedersen, 2009: 719). By actively seeking out CAM, women invest in their own care and in the process of healing (Hughes, 2004), imagining their lives and themselves in the future (Baarts and Pedersen, 2009). In doing so, CAM can be suggested to promote women's nurturing tendencies that are turned onto oneself, subverting traditional gender roles and social order (MacNevin, 2003; Nissen, 2008; Sointu and Woodhead, 2008).

In summary, women's practice of diverse CAM therapies confirms their commitment to participatory and egalitarian relationships, together with approaches to their practice that are influenced by women's shared life experiences and values. Issues of empowerment, control and responsibility in women's practice and use are characterised by multiple tensions, some of which are similar to tensions also noted in biomedical healthcare practices. Women CAM users draw on CAM ideologies and health practices to take charge of their healthcare and to critically engage in re-shaping their identities and lives. As such, women's practice and use of CAM can be described as a form of "progressive individualism" (Scott 1998) that resonates with a feminist agenda. What kind of personal and/or social changes are produced through CAM is explored next.

"The personal is political": women, CAM, and personal transformations

The politicisation of health, postmodern values and social movements associated with feminism, the environment, spirituality and personal growth have played significant roles in the growth of CAM (Astin, 2000; Coulter and Willis, 2007; Melucci, 1989, 1996b). To examine these issues in the context of women's use and practice of CAM, I first explore why women, more than men, are attracted to CAM, and then I focus on the personal transformations that are suggested to result from women's CAM use and practice. In this exploration and its interpretation, I draw on Melucci (1989, 1996a/b) who argues that the politicisation of everyday life and issues relating to quality of life, self-realisation, participation and identity are central to an unfolding "new politics" (Buechler, 2000). He further suggests that social change is brought about through symbolic explorations, expressions of identity and the creation of new cultural norms and practices that pose subversive challenges to political systems.

What is the attraction of CAM for women?

Sointu and Woodhead (2008) link the increasing popularity of CAM, especially among women, with trends in contemporary culture that involve conceptualising the person holistically. The growth of CAM and other "holistic spiritualities" that aim towards "the attainment of wholeness and well-being of body, mind and spirit" (Sointu and Woodhead 2008: 259), they suggest, can be explained, partly, "in terms of their ability both to legitimate and subvert traditional practices and discourses of femininity" (Sointu and Woodhead 2008: 268). Holistic spiritualities, they posit, offer women, and some men, ways of negotiating contemporary dilemmas of selfhood, "including the contradiction between 'living for others' and forging 'a life of one's own'" (Sointu and Woodhead 2008: 268).

CAM practices involve, Sointu (2006b: 507) argues, "the misrecognised turning to discourses and practices that are capable of offering [women users] a sense of self-worth, acceptance and understanding", often through an implicit sense of shared marginality between patient and practitioner that relate to experiences of being women. In doing so, CAM practices enable women to "perform and embody ideals such as self-responsibility and self-actualisation; discourses of wellbeing both reproduce and resist traditional representations of femininity" (Sointu, 2006c: 345). In understanding CAM experiences as embodiment and as "making the body present" (Baarts and Pedersen, 2009), the body offers an arena for self-fulfillment and pleasure beyond the male gaze and women's traditional role of caring for others (Sointu, 2006a; Sointu and Woodhead, 2008). CAM's concern with the cultivation of women's self-nurturing can be seen as a "symbol of women's rebellion against their 'essential' roles of care" for others (Sointu and Woodhead 2008: 273). At the same time, in supporting and encouraging women's self-care and self-fulfillment, CAM recognises and affirms the centrality of the body, health, appearance and physical and emotional sensations as valid areas of attention and care. It encourages women to value themselves as women, as deserving of care and attention.

Thus the argument made by Sointu (2006a/b/c), and Sointu and Woodhead (2008) links closely with the above explorations of women's CAM practitioner-patient relationship, and women's experiences of CAM as empowerment, control and responsibility. It also foreshadows women's experiences of CAM as opportunities for self-care, self-knowledge and identity work, which is turned to next.

Women's CAM use: opportunities for self-knowledge and transformation of self and identity

Women's use of CAM as opportunities for self-reflection, self-discovery and transformation of self and identity emerges as a key theme from several studies (Baarts and Pedersen 2009; Barry 2003; McGuire 2008; Nissen 2008; Scott 1998; Sointu 2006b; Thompson 2003). These authors note that when a woman's new ways of thinking about her body, self and personal life, initiated through her experience with CAM, integrate with broader ways of "being holistic" in all areas of her life, personal and social change begin to merge. That is, some women challenge, resist and change the very circumstances which are counterproductive to their health and/or resist traditional representations of femininity. By using the body to resist and oppose social pressures, women's CAM use can provide resources for managing 'the aches and pains of everyday life' (Rostgaard, 2009), resist biomedical constructions of disease and patienthood, and/or support an emerging sense of power to transform one's self and identity as a woman.

The potential for transformation of self and identity through women's personal engagement with and experience of CAM, and the embodied nature of everyday self-care practices are also illustrated in studies of healing (McGuire, 1988) and

the exploration of alternative health networks in the US (Schneirov and Geczik, 2003). These studies further suggest that the new meanings resulting from the practice and use of CAM, frequently by women, shape powerful connections to others, create new ways of perceiving and being in the world, question biomedical expertise and challenge materialist values. Indeed McGuire (1988) and Schneirov and Geczik (2003: 149) suggest that as individuals experience self-care practices, they move from seeing "illness as a private trouble to illness and health as social problems". This experience, leads to a growing sense of and identification with being part of an alternative community where new value commitments emerge. A similar move is also noted, for example, in women's self-help movements (Taylor 1999) and early breast cancer movements (McCormick 2003).

Like the studies that examine women's practice and use of CAM, Flesch (2010) in exploring the study of acupuncture in the US also notes tensions between traditional notions of femininity and emerging understandings of self for women acupuncture students. Women are attracted to acupuncture as a holistic, compassionate and nurturing medicine, primarily due to their self-perception of being 'innate healers' (Flesch, 2010: 21). Yet women also perceive of themselves as pioneers: they advance a marginal field of medicine (both acupuncture and CAM generally), increase women's access to professional spheres, such as CAM, and aim for financial independence through their work.

Similarly, Gibson (2004) observes in her UK study of the professionalisation of osteopathy, aromatherapy and reflexology, that for women in particular CAM practice presents a twofold opportunity: to reclaim healing from biomedicine and to construct flexible working patterns that facilitate the notion of work as livelihood where personal worldviews and commitments blend with economic aspirations and necessities. While such cultural innovations may challenge traditional gendered work patterns in the public sphere, they may also reinforce women's often vulnerable dependence on part-time work and on other (frequently male) household income (Nissen, 2010).

The search for meaning, quality of life and self-realisation focused on the body that is characteristic of many CAM therapies is also integral to the "new politics" of new social movements. In CAM, women's personal "inner" journeys of change begin to blend with cultural and social change. Thus, CAM becomes more than a distinctive philosophy of health, healing and healthcare and more than an expression of "a new consciousness of the importance of the individual in achieving health" (Coward, 1989: 11) or narcissistic individualism (MacNevin 2003). Rather, CAM becomes a catalyst for change, as one woman notes: "[Western herbal medicine] helps me to focus on changing the way I'm actually living my life – in terms of having exercise, changing my diet and also trying to deal with other issues" (Nissen, 2008: 243). When women change the contexts in which their lives are embedded, the politics of self-actualisation (Giddens, 1991) fuse with resistance to and challenges of gender inequality and oppression (Buechler, 2000). The "personal" of women's lives becomes "political", and cultural and political change merge (Buechler, 2000).

However, the everyday act of "doing CAM" can also be problematic, especially given the multiple demands and challenges women encounter in their everyday lives (Nissen, 2008) and when considering temporal dimensions of CAM use (Broom and Tovey, 2008). More work examining the lived and long-term experiences of CAM users is therefore needed to establish how common or typical the observations presented here are, and/or how they might differ for women and men, for different women and men, and in the context of different CAM therapies and their practice and use in different countries.

In summary, women's practice and use of CAM encourages reflexive, caring and relational attitudes toward oneself, one's body, and emotional and social life. In doing so, I suggest, women's practice and use of CAM provides personal and cultural resources and social networks for producing self-knowledge, resistance to traditional meanings of femininity, and the re/construction of self-identity. This points towards important shifts in everyday socio-cultural values. How such shifts may link with wider social changes is turned to in the following section.

"The personal is *political*": women, CAM and social change

At the beginning of this article I posed the following question: Can we assume that CAM practices primarily maintain a societal status quo and reproduce individualism without collective impacts? It is to this issue of collective impacts of CAM that I now return. As in the previous section, I draw on Melucci's (1989; 1996a/b) new social movement theory. Of particular importance is his conceptualisation of social change which, he argues, is brought about through symbolic explorations, expressions of identity and the creation of new cultural norms and practices. These, he suggests, pose subversive challenges to political systems. In the following exploration of the wider social changes resulting of women's practice and use of CAM, I focus first on the impact of CAM in particular, and then on its impact in conjunction with other social movements. I conclude this section by asking whether women's practice and use of CAM constitutes an effective challenge to the prevailing gender system.

In the previous section, I suggested that women's practice and use of CAM points towards significant shifts in socio-cultural values. But do such shifts imply and/or generate wider social change? In 1988, McGuire predicted that the value changes pursuant to CAM would have "far-reaching consequences for the sociocultural and politico-economic spheres in modern life" whereby even "institutions of the public sphere themselves may have to change to accommodate these individualisms" (McGuire, 1988: 257). The following examples of the impact of CAM consumer movements in shaping healthcare provision illustrate the increasing accessibility of CAM, both in terms of availability and reaching a wider range of people. Klawiter (2005), in her exploration of the experience of one woman cancer patient in the US, demonstrates the huge changes in CAM provision that have taken place over the last decades. While "feeling isolated and powerless" in the late 1970s, 20 years

later the same woman felt like “the captain of a well-functioning team” comprised of various CAM and biomedical professionals. Likewise, Goldner’s (2004) study demonstrates that sustained lobbying of health insurance companies by initially individual CAM users can culminate in collective pressure that leads to changes in healthcare institutions which make CAM more widely accessible.

CAM as a health social movement also interacts with other health movements in producing change. Alternative health movements, women’s (health) movements and disability movements are credited with challenging and changing the customary social practices of biomedicine (Brown et al., 2004; Kuhlmann 2009). Women’s health and women’s alternative health movements in particular critiqued the doctor-patient relationship and biomedical models of health and contributed significant impetus to reconceptualising health and healthcare. Holistic health models, social models of health, and person-centred clinical methods have led to institutional change in the provision of healthcare (Kuhlmann 2009). Likewise, women’s health movements, alternative health movements and other embodied health movements have challenged and changed biomedical knowledge. Such ongoing challenges continue to prompt the “medical modernisation” of biomedicine, leading to innovation in health knowledge (Hess, 2005). At the same time, the democratisation of science through lay/expert collaborations helps to improve science practices, advance the health of the public and reshape the priorities of science and biomedicine (McCormick 2009). In this way diverse movements and their practices produce new knowledge and new ways of seeing the world, which individually and collectively challenge the status quo and existing power structures (Cox and Fominaya 2009).

The observations made here are consistent with considering CAM as a (new) social movement that responds to the needs of individuals in the context of post-modernity or late modernity (Coulter and Willis, 2007; Melucci, 1989, 1996a/b; Stambolovic 1996) and supports social change in healthcare and beyond. But is women’s use and practice of CAM also a challenge and form of resistance to the prevailing gender system? Abu-Lughod (1990) cautions against “romanticiz[ing] resistance”. Instead, she suggests to use resistance as a “diagnostic of power” to interrogate power in specific situations and trace how power relations are formed historically. While women’s contemporary use and practice of CAM highlights, as outlined in this paper, women’s resilience and creativity in refusing to be dominated by systems of gender power, casting a wider net of explorations permits the broader workings of power to be interrogated.

The struggle of biomedicine for professional dominance has been recognised as predominantly a gender struggle (Bourdillon, 1988; Ehrenreich and English, 1976). Similar struggles are occurring with regards to CAM. Flesch (2007) argues that the increasing male domination of CAM via biomedicalisation and co-optation of CAM into biomedical provision converges with processes of professionalisation to define the health work of women. Conversely, women’s

increasing exclusion speaks to the marginalisation of women's role as CAM providers (Flesch 2007). This role is however not without ambiguities, since "[t]he very qualities of CAM that make it an alternative to conventional medicine are, paradoxically, the same qualities that lock women into caring roles devalued by society and by the medical profession" (Flesch 2007: 170).

These dilemmas, as well as the tensions and dilemmas identified throughout this article, suggest that women's use and practice of CAM might destabilise traditional gender roles rather than overcome them. As such, women's CAM practices can be seen to represent a form of dissent and resistance and simultaneously a lived and embodied vision of alternative identities and communities (McGuire 2008) that are characteristic of "new politics" and NSM.

Conclusions and an emerging research agenda

Healthcare practices are political actions which legitimate or challenge practices, norms and ideas, as well as existing knowledge that reflect socio-cultural, political and economic structures. CAM is no exception to this. The interrogation of the interplay between women's practice and use of CAM, personal transformation and social change explored through this review of literature on women and CAM highlights that when gender constitutes an integral part of analysis and theorising, combined with a broader understanding of "the political", new meanings and perspectives emerge. The explorations presented suggests the following conclusion: Women's diverse practices and uses of CAM offer an opportunity to fulfill and confront traditional gender roles and discourses of femininity, and can provide new resources for personal transformation and the promotion of women's autonomy. Furthermore, women's practice and use of CAM contributes towards promoting and achieving wider social change. This takes place, for example, through: the destabilising of traditional gender roles; the changing of the customary social practices of biomedicine; the creation of new epistemic paradigms; the development of new working practices; and the shaping of alternative communities.

As noted throughout this article however, many of these aspects, and the issues related to them, go hand in hand with tensions and dilemmas concerning multiple dimensions of power – from personal and inter-personal, to social, cultural, economic and political. Therefore, considerably more work that takes these issues into consideration is needed. For instance, gender (and other social differences) and subjectivity are integral to processes of change, and this paper has centred specifically on women, noting the impact of CAM on women's traditional gender roles and identity work. Future explorations of men's practice and use of CAM and/or individual therapies may equally identify challenges to their traditional gender roles and normative patterns of masculinity (see e.g. Sointu 2011) that tend to perceive emotional expression, asking for help and caring for one's body and health as feminine (Courtenay, 2000; Magnuson, 2008).

Furthermore, the heterogeneity of CAM users, practitioners and therapies calls for more work to establish how common my conclusions are, for example in a wider range of situations, such as: how they might differ for women and men; for different groups of women and men; between different CAM therapies; in different kinds of CAM healthcare settings, including CAM that is integrated into biomedical provision; and in a wider range of countries. Rather than drawing on existing definitions or categorisations of CAM, other ways of thinking about CAM therapies might usefully come into play here. These might include: therapies which are associated with extensive conversations (e.g. homeopathy, Western herbal medicine, naturopathy); "science-oriented" therapies, such as chiropractic, osteopathy, acupuncture; "body therapies" such as massage, reflexology, shiatsu; distinctive philosophies, such as Ayurvedic medicine or traditional Chinese medicine; esoteric approaches, including crystal therapy and spiritual healing. Such considerations might then help to identify which kinds of CAM therapies have the potential to be empowering to its users, what kind of personal and/or social change they may support, and whether the setting in which CAM is practised (e.g. in biomedical healthcare or in private practice) influences the practitioner-patient relationship and impacts on how CAM users experience issues around, power, empowerment, control and responsibility in their engagement with CAM.

Related to this, and also to ongoing critiques of CAM (e.g. Baer 2004), is the question of how CAM practitioners understand the notion of holism and how different constructions of holism inform the practice of a CAM therapy and whether this has implications for users' experiences of CAM and/or a specific therapy (see e.g. Nissen 2008; 2011).

As noted, CAM is not an isolated healthcare practice or a health social movement that is unrelated to other movements. The centrality of foregrounding the body and the embodied nature of knowledge production is shared with women's health movements and also critical to other embodied health movements (EHM), including disability, breast cancer, and AIDS movements, and local and national toxic waste protests (Brown, et al. 2004). As such, EHM, similar to women's practice and use of CAM examined here, pose critical challenges to political power and biomedical authority and have contributed to transforming individual experiences and the provision and practice of healthcare (Brown, et al., 2004; Klawiter, 2005). Like CAM, EHM also critique, resist and change existing scientific and biomedical knowledges and practices. It is here in particular that overlaps of CAM with other movements of social change can be identified. More work is however needed to provide in-depth knowledge of how CAM (and individual CAM modalities) functions as a (new) social movement and what contributions are made to social and epistemic changes.

Examining these and other issues makes a more complex picture of CAM and potential change processes possible and furthers our understanding of health social movements. By focusing on women's use and practice of CAM, I hope to have contributed to this rich research agenda.

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