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EXPLAINING THE SUCCESS OF
THE ALTERNATIVE HEALTH CARE MOVEMENT:
HOW INTEGRATIVE MEDICINE IS EXPANDING WESTERN MEDICINE

DISSertation

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
Melinda Ann Goldner, B.A., M.A.

The Ohio State University
1998

Dissertation Committee:

Professor Verta Taylor, Adviser

Professor J. Craig Jenkins

Professor Robert Kaufman

Approved by

Verta A. Taylor
Adviser
Department of Sociology
ABSTRACT

Alternative medicine is attracting public attention at the same time that it is expanding the practice of Western medicine. More consumers are using and practicing alternative techniques such as acupuncture and yoga. As they empower themselves and make the necessary personal changes, they influence their friends and family. These activists also influence society by educating the public, lobbying financial and governmental agencies, and spending their own money on these techniques. These personal and political actions have collectively caught the attention of insurers, physicians, governmental agencies and the media.

Researchers typically conceptualize alternative medicine as a set of techniques or beliefs. Instead, I argue that we need to examine alternative medicine as a social movement, because it is this collective effort that has led to these recent changes. Through interviews with forty alternative health care practitioners and clients, and observations of five alternative health care organizations in the San Francisco, California Bay area, I found that most practitioners and clients identify with an alternative health care movement and define their participation as activism. Though their resistance to Western medicine often involves individual acts, collectively they are forming an alternative ideology and structure, and having a larger impact
since they identify with a seemingly cohesive social movement that challenges Western medicine collectively. Since the alternative health care movement has diverse participants, strategies and organizations, I argue for a synthesis between resource mobilization and new social movement theories.

The authority and dominance of Western medicine are beginning to dismantle, whereby power has moved away from the physicians to financing and regulatory agencies. These political changes have led to a newer trend toward integrative medicine, which combines Western and alternative medicine. Though integrative medicine signals movement success, I use institutional theories to explore how Western medicine can respond to this threat. Though some physicians are incorporating alternative medicine, they still have more power than alternative practitioners. In this study I specify the dynamic relationship between the political opportunity structure, a movement and their opposition. I argue that activists need to control holistic ideology to prevent Western medicine from co-opting their personnel and techniques.
Dedicated to Jeff
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VITA

April 30, 1968 ......................... Born - Wooster, Ohio

1990 .............................................. B.A., Tufts University,
                                      Medford, Massachusetts

1993 .............................................. M.A., Washington State University,
                                      Pullman, Washington

FIELDS OF STUDY

Major Field: Sociology

    Studies in: Medical, Social Movements, Gender
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CHAPTER 1

INTRODUCTION

"I feel like I'm no longer a voice in the wilderness even though there have always been like-minded colleagues [with which] to converse."

Alternative medicine is attracting public attention at the same time that it is expanding the practice of Western medicine.¹ The public's fascination with alternative techniques such as acupuncture and yoga is exemplified by the increase in news stories, Web sites and the amount of homeopathic remedies and vitamin supplements in the local supermarket.² News stories on alternative medicine have even appeared in mainstream sources such as The Nightly News with Tom Brokaw and TIME Magazine. A Gallup poll showed that 19% of respondents, or 60 million individuals, had

¹There are many terms in usage for alternative and Western medicine. Some prefer the term "holistic" (Alster 1989; Berliner and Salmon 1979; English-Lueck 1990). Even though I use both terms synonymously, I prefer the term "alternative" because it reflects a contrast in activists' strategies and identities when I refer later to "integrative" medicine. Though authors use "traditional" and "allopathic" medicine interchangeably, I prefer the term Western medicine. The former term ignores the fact that Western medicine is a relatively new model, and historically they used the latter term solely in contrast to homeopathy. Please refer to Table 1.1, at the end of this chapter, for a comparison of these models.

²Web sites include Ask Dr. Weil, Yahoo!'s Alternative Medicine page and General Complementary Medicine References. Natural remedies constitute a multi-million dollar industry (Klink 1997/1998:22). Pharmacies sell herbal medicines alongside Western medicines. For example, Longs Drugs had a full page insert in the San Francisco Chronicle (July 23, 1997:C1) advertising dietary supplements such as Ginseng and Ginkgo Biloba and herbal remedies such as Goldenseal.
used herbal products in 1996 alone (Kathleen Halloran, editor of the Herb Companion, as quoted in Davis 1997:13). Alternative medicine is beginning to transform Western medicine, especially given such high levels of consumer interest. For example, some physicians are referring patients to alternative practitioners, while hospitals from California to Massachusetts are offering these techniques themselves (Barasch 1992). How are we to understand the phenomenal success of alternative medicine? In this study I use social movement theories to explain these changes.

A study led by Dr. David Eisenberg (1993) documented the increase in alternative medicine. These researchers found that 34% of individuals in their national survey had used an “unconventional therapy” in 1990 (248). Typically patients sought treatment for “chronic, as opposed to life-threatening, medical conditions” (246). Respondents were most likely to have tried relaxation techniques, chiropractic and massage, and least likely to have tried acupuncture and folk remedies (248). College educated, higher income non-African American individuals between the ages of 25 and 49 were most likely to try these techniques (248). Eighty-nine percent did not have a recommendation of a medical doctor and 55% paid the entire cost of treatment out of pocket (249-250). Overall, this study shows that more individuals are using alternative medicine than previously thought. Since this study was published by the New England Journal of Medicine, a well-known and respected medical journal, physicians as well as alternative practitioners are likely to know about the findings.

Problems with Western medicine provide a partial explanation for the increased use of alternative medicine, because these problems drive consumers to find alternatives (Berliner and Salmon 1979:43; Lowenberg 1989:53-63). Consumers turn to alternative medicine since they perceive
health care reforms within Western medicine to be slow or non-existent, and since alternative health care practitioners construct their clinics in ways that overcome some of these limitations (Hainer 1996:4D). Prior research has found that individuals seek alternative medicine because they do not like the impersonal care they receive in the Western model, which they believe focuses more on technology and account management than individuals (Hoffman 1989:39). Many individuals feel Western physicians are emotionally distant, impersonal and rushed (TIME 1996:43). The result is that they feel alienated and objectified as patients. Alternative medicine provides clients with a sense of control, and it is comprehensive and simple (Alster 1989:184). “Holistic medicine is...to a large extent, filling a void that has been created in part by the technocratization of medicine” (Rosch and Kearney 1985: 1407).

Patients have begun to see problems within Western medicine for a variety of reasons, including physicians’ attitudes, societal expectations and health care financing. The problem could stem from physicians themselves, especially their training. Hafferty (1991) argues that physicians learn emotional detachment in their medical training since faculty and students ridicule physicians who display emotion and question their abilities as physicians (48-9, 76). Other authors argue that the trouble with medicine is not specifically with physicians, but with a cultural and social system that diminishes the human side of health care, and overestimates what medicine can do (Konner 1993:xviii, xxi). Western medicine has made great advances treating acute trauma, but not chronic illness (Mattson 1982:138). As Western medicine fails in many cases, but expectations are raised, many consumers are left feeling dissatisfied. Another explanation for patients' dissatisfaction with Western medicine lies in health care financing. Managed care systems can
intensify consumers' feelings of dissatisfaction, because characteristics of these systems can militate against the relationship between physician and patient. For example, patient alienation stems from the ability of insurance companies to make medical decisions under managed care; whereas, physicians and patients made these decisions before managed care (Bloom 1987; Koop as quoted in TIME 1996). As administrative and financial agencies manage health care with an eye to finances, rather than patient care, patients are also taking a more consumerist stance by voting with their dollars (Lowenberg 1989:53-63). This has translated into an ever growing interest in alternative medicine.

Consumers are certainly contributing to the dramatic rise in alternative medicine by publicly criticizing Western medicine, and turning to alternative medicine; however, an alternative health care movement is actively promoting and legitimizing alternative techniques, as well. Many practitioners and clients identify with an alternative health care movement and define their participation as activism (Lowenberg 1989:73; Schneirov and Geczik 1996:640-641). Though their resistance to Western medicine often involves individual acts, collectively activists are forming an identity and alternative structure, and having a larger impact since these individuals identify with a seemingly cohesive social movement that challenges Western medicine collectively. Group organizing encourages this collective effort, such as the location of alternative health care in clinics with multiple practitioners (Sirott & Waitzkin 1984:260). Western medicine would not be concerned with alternative health care if only small numbers of disconnected individuals were seeking this type of care. Quite the contrary, increasing numbers of patients are leaving Western medical clinics, seeking health care in an alternative model, and being vocal about the limitations of allopathic
medicine. Most importantly, these individuals can have a larger impact since they represent a seemingly cohesive social movement that challenges allopathic medicine collectively.

It is useful to conceive of alternative medicine as a social movement since it is this collective effort that has led to recent changes in both Western and alternative health care organizations. I argue that it is necessary to examine alternative medicine as a social movement to appreciate its recent success, especially the inroads activists have made into Western medicine. Activists are beginning to form more extensive networks with each other and physicians given political opportunities such as changes in health care financing and the corresponding changes in Western medicine or the movement's opposition. The new trend toward integrative medicine has emerged in this political context of rising frustrations with Western medicine, and cultural context of demand for alternative medical models.

A major sign of the movement's success is the fact that activists are now developing an integrative model of medicine that combines Western and alternative techniques, rather than advocating an alternative model that does not include physicians or Western medicine. Aakster (1986) puts the integrative model somewhere in between the pharmaceutical and holistic models of health care (269). In integrative medicine activists maintain the ideology of alternative medicine, yet alter the boundaries of who they include in this model and how these participants identify. Ideologically, practitioners see the patient as a whole person that needs physical, emotional and spiritual healing in the integrative model. Therapeutically, practitioners use a combination of Western and alternative treatment modalities. Lowenberg
(1989) argues that we need data on what happens when the two models of medicine intersect (93). I aim to fill this gap by examining why both sides have shown interest in this new medical model.

Activists within the alternative health care movement advocate integrative medicine for ideological and strategic reasons. Alternative practitioners require multiple therapies since they believe each individual is unique and responds to treatment differently (Alster 1989:101). These practitioners advocate integrative medicine as a way to recognize the inadequacies of relying on a sole technique. Rarely can one practitioner have all of the knowledge and expertise necessary to bring individuals back to health, especially since ideologically they recognize that healing entails the body, mind and spirit. On a strategic level, alternative practitioners know they will gain legitimacy and possibly insurance reimbursement if they work with recognized medical professionals with more power and authority in our society. Activists within the alternative health care movement have started to advocate integrative medicine as a practical strategy to ensure their survival in a political climate that is more favorable, but volatile.

It is most striking that some physicians, hospitals and insurance companies have shown limited, but growing, interest in integrated medicine. This is the explicit aim of organizations such as the American Holistic Medical Association, comprised of approximately 350 physicians and osteopaths (Wolpe 1990). Goldstein and his co-authors (1987) argue that this group may be more liberal therapeutically, but remain conservative scientifically since they evaluate the usefulness of holistic techniques based

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3Nurses are not new to incorporating alternative medicine into their work (Mattson 1982:14; Tubesing 1979:131). I focus on the change in physicians' attitudes toward alternative medicine since they have more power and these changes are more recent.
on scientific criteria (106). Individual physicians also advocate integrating specific techniques into Western medicine. Dr. Elson Haas (1992) has moved toward the practice of "integrated medicine" and "scientific nutrition" that balance scientific and intuitive nutritional medicine (3). Dr. Larry Dossey (1996) argues that medical practitioners should view prayer as complementary to Western medicine (5). As physicians advocate alternative medicine, the hospitals where they work have begun to incorporate some of these techniques, as well. For example, patients can learn yoga and meditation at the University of Massachusetts Medical Center in Worcester or the Deaconess Hospital in Boston (Barasch 1992:8-9). Finally, many health maintenance organizations (HMOs) "are sensing a lucrative opportunity in the public's infatuation with alternative therapies" (Russell 1996:A4). Since managed care creates incentives for clinics to keep their patients healthy, these organizations are increasingly interested in alternative health care techniques that focus on wellness and prevention of disease (Dr. Dean Ornish as quoted in Russell 1996:A17). In practice, this interest has translated into integrative clinics that combine allopathic and alternative medicine such as two Kaiser Permanente clinics in northern California. The question is whether these changes signal a victory for the movement, or whether physicians and Western medical organizations will simply co-opt alternative techniques for their exclusive use. In other words, will activists continue to control the ideology and techniques they have worked so hard to legitimize? I argue that it is necessary to use social movement perspectives to address this question.

Few researchers describe alternative medicine as a social movement or use social movement perspectives to understand alternative medicine as a modern social phenomenon (see Schneirov and Geczik 1996 for an
exception). Previous researchers have typically conceptualized alternative medicine as a set of techniques or beliefs extensively detailing the ideology and origins behind alternative techniques (Jones 1985:vii; Lowenberg 1989). Yet, understanding the explosion of interest in alternative medicine, and this newer development toward integrative medicine, is a question of how social movements interact with their opposition, and take advantage of political opportunities. In this study I examine the alternative health care movement in the San Francisco, California Bay area in order to understand why these activists have been so successful and how Western medicine has responded.4 I also examine how the collective identity of participants changes over time since the movement’s strategy of integrative medicine is relatively new and vastly different from earlier stages in the movement. I show how the different collective identities influence organizational structure, funding sources, discourse, services and interactions within social movement organizations. Theoretically, I use social movement perspectives to frame this discussion, and understand the new trend toward integrative medicine. I draw from resource mobilization theory to explain the role of social movement organizations, and the importance of political factors on the success of the movement. I use new social movement perspectives to explore the equally important role of collective identities and submerged networks for the nature and success of the movement.

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4 Though alternative medicine has been around for decades or centuries, especially in other countries, I focus on the recent rise in alternative medicine. Gevitz (1988) argues that the first important challenge to orthodox medicine was Thomsonism, especially since he knew how to market his approach (viii, 43). The largest rival in the 19th century was homeopathy, however (Gevitz 1988:ix). Other early alternative techniques include hydropathy, physical education and vegetarianism (Wardwell 1994).
Alternative Medicine as a Social Movement

I examine alternative health care as a social movement, rather than a set of "non-conventional" techniques or beliefs as prior research has done (Lowenberg 1989). I find that most practitioners and clients I interviewed identify with an alternative health care movement and define their participation as activism. I define activism broadly as participation in alternative health care as practitioners or clients, so long as they identify as activists in the movement. Given the wide range of definitions of alternative health care, I did not want to exclude any individuals who considered their medical care alternative, especially if they identified with the alternative health care movement.

A social movement is "a collectivity acting with some degree of organization and continuity outside of institutional channels for the purpose of promoting or resisting change in the group, society, or world order of which it is a part" (McAdam and Snow 1997:xviii). Collective action, organization, continuity and goals are the key elements in this definition. Organizations within the alternative health care movement exemplify collective action. National groups lobby for alternative medicine through legislative channels, for example. Organizations such as these desire a more holistic type of health care that changes the relationship between practitioner and provider, and shifts the goal away from illness to wellness. There has been continuity in this goal, collective action and organization over time. Most theorists identify the late 1960s and early 1970s as the early stages of the contemporary movement (Berliner and Salmon 1979; Otto and Knight 1979).

Theorists classify social movements based on the amount and type of change they seek. Examining the amount of change social movements seek, Smelser (1962) distinguishes between reform and revolutionary movements.
The alternative health care movement is a reform movement, under Smelser's model, focusing primarily on lifestyle, and secondarily on political issues (Mattson 1982:43-44). Though activists attempt to change the way governmental and financial agencies perceive alternative medicine, they first try to change the way individuals think about their health. Aberle (1966) argues that social movements seek either partial or total change in individuals or social structures by focusing on both the type and amount of change (316). He identifies alternative, reformative, redemptive and transformative movements. According to this typology, the alternative health care movement is an alternative movement since it seeks partial change in individuals (Aberle 1966:317). Both of these classifications can capture the fact that the alternative health care movement focuses to a great extent on personal change in individuals. Some observers do not recognize alternative medicine as a typical social movement, because of this heavy focus on lifestyle issues or personal change.

New social movement theorists\(^5\) have tried to change our thinking about personal change movements by documenting historical changes that have led to this type of activism. It is important to look beyond participant's perceptions and these basic social movement typologies, because "new" social movements such as alternative health care emerged within a specific social and historical context. European scholars such as Habermas, Touraine, Offe, Melucci, Inglehart and Klandermans argue that recent movements such as environmentalism and feminism have "new" targets, grievances, ideologies,

\(^5\)Buechler (1995) argues that it is more accurate to refer to new social movement theories, because there are major disagreements among theorists. Johnston et al. (1994) add that it is an approach not a theory, because the propositions have not been verified empirically. While acknowledging these critiques, for simplicity I still refer to new social movement theory.
constituencies and action forms. Structural changes such as modernization and economic growth have meant that the state has encroached onto other arenas of life, thus individuals seek autonomy from the state (Habermas 1981; Offe 1985). For example, the home school movement emerged in response to the “colonization” of families by the institution of public education (Mayberry et al. 1995:102). Rather than target the state or economy as previous movements did, these “new” social movements often target civil society (Cohen 1985).

Theorists consider the grievances of new social movements post-materialist and their ideologies anti-modernistic (Habermas 1981; Klandermans and Tarrow 1988). Post-materialist implies that there has been a certain level of affluence achieved in society, thus individuals can turn their attention away from material needs like food and shelter to focus on post-material needs such as peace. The ideology is considered new, because new social movements seek personal identity and autonomy (Dalton and)

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6Since theorists stress the newness of these movements, it is important to point out that there is evidence to the contrary. D'Anieri et al. (1990) examined the Chartist movement in 19th century England, the Oneida community of the antebellum United States and West German Peace Movements following World War II. The authors found that these movements used similar tactics, strategies, goals and organizational forms as the supposedly “new” movements. The Oneida community developed antihierarchical, collectivist organizations, for example. Other scholars suggest that social movement communities existed in earlier movements, and played a vital role. Rupp and Taylor (1987) examine the feminist communities of the 1940's and 1950's. They find that the National Woman's Party insulated activists from a hostile political climate, and sustained movement activity. See Calhoun (1995) for a discussion of how the term “new” overlooks the numerous movements, pre-dating the 1960s, that focused on personal transformation. Though I agree with most theorists who question what is new about contemporary social movements, I retain the use of the term “new social movements” to remain consistent with the theoretical approach.

7New social movement theorists argue that grievances are essential to mobilization; whereas, Resource Mobilization theorists downplay their role (Buechler 1990).
Kuechler 1990). An example would be the pro-choice movement that values women's autonomy from the state, specifically her right to control her own body.

Theorists consider the constituencies new because they supposedly transcend class unlike many movements of the early twentieth century (Kriesi 1989). Participants tend to come from the new middle class such as young, educated workers employed in public and human service positions (Offe 1985). Yet, individuals are mobilized on the basis of social statuses such as race and sex, and activists often act on behalf of collectives (Klandermans and Oegema 1987). For example, the environmental movement in the United States may attempt to speak for the citizens of Brazil when activists fight to protect the rain forests.

Finally, new social movement theory argues that these movements have new action forms. Participants' activism is both external and internal meaning that activists engage in direct action tactics, as well as politicize everyday life (Kaufmann 1990). The politicization of everyday life is similar to Breines (1982) notion of "prefigurative politics," which means that through their daily lives these individuals try to "prefigure" a better society, or live in such a way that brings about the social changes they desire. Rather than formal organizations, these movements are concentrated in decentralized and autonomous submerged networks that often provide everyday needs (Buechler 1990; Melucci 1989). For example, feminist bookstores provide referrals for roommates and social activities. Collective identities are central to these social movement communities (Melucci 1995). They entail shared definitions, beliefs, practices and experiences that produce solidarity among a group of people (Taylor 1989; Taylor and Whittier 1992; Whittier 1995).
Insights from new social movement theory can be applied to the alternative health care movement. Many consumers are frustrated with Western medicine, yet these problems cannot fully explain the increased use and acceptance of alternative medicine. It is important to look at other factors that have played a role historically, because public dissatisfaction cannot fully explain the movement’s growth (Alster 1989:184). We must also examine the social context beginning in the 1960s. Following new social movement theory, the alternative health care movement emerged in a period characterized by the prominence of science, technology, state administration and the economy (Habermas 1981, 1987). Together, these elements lead to a society that emphasizes centralized, rational, bureaucratic efficiency, not active participation (Schneirov and Geczik 1996:628). In this model, the "lifeworld," or where individuals try to create meanings and participate actively, becomes "colonized" or marginalized by the state (Habermas 1987). The state has increasingly intervened into the private lives of individuals, so individuals resist these changes in the economy and modernization by creating "new" social movements. Following a focus on "life politics" or quality of life issues and resistance to this "colonization" or institutional intervention (Giddens 1991), the alternative health care movement asserts the "principles of individualism and self-reliance, and the attempt to live in a way that is consistent with one’s worldview" (Mayberry et al. 1995:102). These activists, members of the new educated middle class, fight to define their lifestyle, and challenge dominant cultural codes (Kriesi 1989; Lichterman 1996).
The new social movements of the 1960s and 1970s have influenced the alternative health care movement. Alternative health care was influenced by different counterculture movements (Alster 1989:36; Mattson 1982:69; Sirott & Waitzkin 1984:252-4, 260; Starr 1982:392) that raised issues such as peace and ecology (Wolpe 1990:915), human potential or self-fulfillment (Alster 1989:36; Lowenberg 1989:67-9; Mattson 1982:69), free clinics (Salmon 1984:229; Sirott & Waitzkin 1984:252-4, 260), and feminism (Lowenberg 1989:67-9, 78; Mattson 1982:67; Miles 1984:125; Sirott & Waitzkin 1984:252-4, 260; Wolpe 1990:915). The alternative health care movement has used their tactics and shared their personnel. Feminism provides a good example. Lowenberg (1989) found that many activists in the alternative health care movement participated in the women's movement. Even more significant, activists in the alternative health care movement have borrowed meanings, symbols and consciousness from these social movements (Lowenberg 1989:71-8; Meyer and Whittier 1994). As feminists enter the alternative health care movement, they bring with them this consciousness. Feminism led to a specific consciousness among consumers that demystifies and challenges the power of the medical profession through individual empowerment (Salmon 1984:231; Starr 1982:380, 391; Taylor 1996).

Why did the alternative health care movement specifically emerge in this political context of increasing intervention into the private lives of individuals? One "leading instrument of colonization" is the development

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8 Mattson (1982) argues instead that alternative health care is part of a larger social movement not just focused on health, but personal and social transformation (Mattson 1982:160). Alster (1989) argues that this wider base increases its popularity since their message is broader and resonates with more people (Alster 1989:76).

9 Ruzek (1978) argues that the alternative health care movement is part of the women's health movement which is separate from feminist movements (184, 217).
of the medical industrial complex that has led to the medicalization of social problems (Schneirov and Geczik 1996:627). Medicalization entails subsuming issues and conditions under the medical model when they previously fell outside this institution. The implication is that individuals need to get medical help to cure or treat the problem from a health care professional, thus medicalization increases the control physicians have over health and seemingly non-health issues (Lowenberg and Davis 1994:582; Taylor 1996). Physicians increasingly define alcoholism and pre-menstrual syndrome, for example, as medical conditions that require medical intervention and control. We can see that the medicalization of society has led to resistance against this view.

Activists within the alternative health care movement resist this medicalization within Western medicine. Schneirov and Geczik (1996) argue that Western medical institutions emphasize technology, intervention and profit (642). Physicians conceptually reduce patients to objects since they are unable to participate actively in their health care. Individuals dislike the ways physicians have tried to assume more control over their health and life. They want to be more active participants in their health care. The alternative health care movement is an attempt to “reconnect health and illness to the lifeworld” (Schneirov and Geczik 1996:628). Activists argue that health care should return to a focus on relationships between providers and patients, and acknowledge that illness is not disconnected from the people who have them. Activists frame their identities to argue against medicalization through its emphasis on individual responsibility and egalitarian relationships between practitioners and clients (Lowenberg 1989:226).¹⁰ They attempt to

¹⁰ However, some researchers argue that alternative health care also medicalizes other aspects of our lives such as expanding health to include lifestyle and spiritual well-being (Lowenberg 1989:226; Lowenberg and Davis 1994:581). Lowenberg and Davis (1994) argue
deprofessionalize medicine by seeking alternatives to Western medicine (Lowenberg and Davis 1994:581; Sirott & Waitzkin 1984:247). What is more important, they define this involvement as activism since it involves an active rejection of the Western medical model, development of an alternative model, and connection to something much larger than their individual participation. Taylor (1996) draws similar conclusions in her work on the postpartum depression self-help movement. Though activists have medicalized their experiences with postpartum illness to a certain extent, they challenge expert knowledge, encourage alternative understandings and approaches, and advocate self-help strategies. Activists in the postpartum self-help movement also make a similar shift from individual participation to collective identification with a movement that combines personal change with institutional transformation.

Habermas cannot necessarily help us understand how activists interact, though his ideas on colonization can help explain why the alternative health care movement emerged. For these reasons, Schneirov and Geczik (1996) turn to Melucci’s work. Melucci (1989) argues that social movements entail submerged networks that attain goals, but also allow participants to “self-consciously practice in the present the future changes they seek.” Since these submerged networks are often more interested in everyday life and autonomy, they do not always branch out into the political sphere. In isolation, submerged networks do not constitute a social movement. Consequently, in order to classify alternative health care as a social movement Schneirov and Geczik (1996) suggest that it operates on two levels simultaneously. First, the alternative health care movement acts as an

against a simple generalization since alternative health care, for one, entails both processes (595).
interest group through lobbying groups such as the Nutrition Health Alliance and professional associations such as the American Holistic Medical Association. I observed the local chapter of a national lobbying group to understand how interest groups try to mobilize support through advocating legislative reform, educating the general public, acquiring resources and developing coalitions (630). Second, the movement operates in submerged networks. I observed three clinics that attempt to create and sustain an alternative way of life through sharing information (631).

Submerged networks have played a larger role within the alternative health care movement than formal organizations such as lobbying groups. For this reason, Gusfield (1994) would define alternative medicine as a fluid movement. Even though fluid movements are more difficult to specify than a linear movement, or one based on formal organizations, fluid movements have certain characteristics that are significant. Though some social movement organizations within the alternative health care movement focus on political change, this movement lies primarily outside the political arena. Rather than focus on change in society and institutions, this movement focuses first on change in individuals (Alster 1989:96; Mattson 1982:43). Following from this focus, activists use different strategies to pursue their goals. The alternative health care movement focuses on internally oriented informal strategies, rather than the formal strategies many social movements use such as lobbying. For example, activists create alternative institutions or "social movement communities" (Buechler 1990; Rupp and Taylor 1987) that prefigure a different way of living and working (Breines 1982; Case and Taylor 1979:4). These action forms politicize everyday life. The alternative health care movement is embedded in everyday actions and interactions in addition to organized and directed action (Gusfield 1994). Some participants define
their lifestyle changes as a form of activism, because they put their ideology into practice. These are "action[s] taken with the recognition that it is not isolated and individualistic" (Gusfield 1994:66). Membership is fluid in this type of social movement, meaning that "movements can have consequences and influence behavior without the kind of commitment or ideological agreement that is often posited for them" (Gusfield 1994:70). Many participants perceive their actions as activism that is connected to something much larger.

Activists create and maintain collective identities within this submerged network of social movement communities. Collective identities are oppositional because activists resist dominant representations, beliefs and discourse. As activists interact they establish boundaries that define who is inside or outside the movement, and develop the movement's ideology (Taylor and Whittier 1992). In this study I will demonstrate that the collective identity of alternative activists excludes Western practitioners and techniques, though the newer identity of integrative medicine includes both. I will also show that the movement's ideology, a key component of participant's collective identity, is critical to preventing co-optation of its personnel and techniques. Activists within the alternative health care movement experience these changes in beliefs and identity through social movement communities such as alternative clinics.

Schneirov and Geczik (1996) argue that clients construct a "moral" boundary between alternative health and the outside world through using alternative medicine. Activists believe that individuals outside this boundary are excessive, passive and undisciplined (638). Schneirov and Geczik identify four sets of changes that a person goes through upon using
alternative medicine. These changes make the person committed not just to a type of medicine, but to a community and way of life (640). First, clients develop a relationship with an alternative practitioner. Since these relationships are so different from the ones formed with physicians, they begin to evaluate other relationships with medical providers. Second, friends and loved ones have to adjust to the new life demanded of these individuals (641). Alternative medicine often requires lifestyle changes so the person becomes increasingly different from these other individuals. This may strengthen their commitment to alternative health care as these individuals compare their health to others and see the value in what they are doing. Third, clients may increasingly associate with others who are also “different” since they understand their motivations and needs (641). As they immerse themselves in this new community their identification with it also increases. Finally, the person creates new “value commitments” since they interact in the movement with diverse individuals. For example, one-third of the activists in Schneirov and Geczik’s sample also identified as feminists (641). Participants develop oppositional identities in this way. During each stage participants are taken “from the immediacy of everyday life to a connection with others and with larger issues, from illness as a private trouble to illness and health as social problems” (Schneirov and Geczik 1996:640).

New social movement perspectives cannot capture all of the facets of the movement since the alternative health care movement is so diverse. Even though this perspective recognizes the importance of collective identity and submerged networks, new social movement theorists downplay formal social movement organizations and political processes (Klandermans and

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11 Schneirov and Geczik (1996) explain how clients, not practitioners, develop collective identities since they find that most practitioners are first clients of alternative medicine (640).
Tarrow 1988). Consequently, I argue for a synthesis between resource mobilization and new social movement theories. New social movement theory can help us see why the alternative health care movement emerged, and how it is a fluid movement that is not only focused on political change, but also personal changes. On the other hand, resource mobilization theory enables us to see the role collective organizations, such as interest groups, can play in a social movement, as well as understand the political and institutional context in which the movement exists.

Resource mobilization theory, the dominant social movement theory in the United States (McAdam 1994), emerged in the 1960s and 1970s as a critique of traditional approaches. Downplaying the role of grievances, theorists in the resource mobilization tradition refocused their attention on structural or organizational aspects of social movements. Movement emergence is the result of increases in resources and changes in the political environment or opportunity structure. Resource mobilization theorists redefined social movements as normal political activity, and they consider participants and their actions to be rational.

There are two strands of resource mobilization theory, which differ more in emphasis than political assumptions. First, McCarthy and Zald's (1973, 1977) organizational-entrepreneurial model examines professional social movement organizations. These organizations use paid leaders to speak for a constituency, and rely on external resources such as elite support. Second, the political process model explains movement emergence by internal and external factors (McAdam 1982; Tilly 1978). McAdam (1982) identifies two internal factors; cognitive liberation and indigenous organizational strength. Both were necessary to the Civil Rights Movement as groups need individuals with a collective conscience to participate, but
organizations in which to be active. Factors external to social movements,
such as support from the government and political elites, comprise the
political opportunity structure. Broadly defined, the political opportunity
structure refers to how vulnerable or receptive the political environment is
to social change (Eisinger 1973; Jenkins and Perrow 1977; McAdam et al.
1997/1988; Tarrow 1994; Tilly 1978). When the political opportunity structure
becomes more favorable, either through the receptivity or vulnerability of
inside groups or political and economic systems, activists gain access to a
variety of resources.

Several studies illustrate the importance of the political opportunity
structure for movement emergence. For example, the civil rights movement
emerged after African Americans migrated north and registered to vote in
large numbers (McAdam 1982). These changes made the political system
more vulnerable. At the same time, the Democratic party's rise to power
made the political system more receptive to the movement's goals and
claims. The second wave of the women's movement emerged, in part, from
former President Kennedy's creation of the Commission on the Status of
Women (Rupp and Taylor 1987). The women involved in this commission
developed leadership skills and communication networks, and their
grievances gained legitimacy. Likewise, coalition support from liberal
organizations, along with divisions within the government, aided the farm
worker's movement (Jenkins and Perrow 1977).

I rely on resource mobilization theory to highlight the critical role
collective organizations play within movements, especially since they put
ideas into practice (Gusfield 1994). Since beliefs and meanings are so central
in the alternative health care movement, I have observed three alternative
health care clinics and a professional organization to see how these collective
identities affect practitioners' actions and interactions, and leads them to perceive their work as a form of activism. Informally, the practitioners advance their ideas and challenge allopathic medicine through the structure of their clinics. For example, many of the practitioners I interviewed believed the relationships they developed with clients were critical, because they put their beliefs into practice. More importantly, these were often deliberate strategies to improve upon the weaknesses of Western medicine and provide an alternative model. In this way, many of these practitioners defined this strategy as a form of activism.

We miss other forms of collective action by using this theory alone since resource mobilization theory uses formal organizations as the baseline for a social movement. The alternative health care movement does not have one identifiable or central organization that unifies the entire movement. Rather, it is a diffuse and amorphous movement comprised of diverse clinics, activist organizations and individuals (Alster 1989:5; Salmon 1984:232). The movement's cohesiveness has come from beliefs, meanings and definitions (Fine 1995; Hunt et al. 1994; Melucci 1995; Snow and Benford 1992; Snow et al. 1986; Taylor and Whittier 1995).\(^\text{12}\) Participants promote these through written material and interaction, rather than structural and organizational aspects that resource mobilization theorists emphasize (Alster 1985:5; Gusfield 1994; Lowenberg 1989:16). A collective identity allows diverse and often disconnected individuals to develop shared meanings, similar experiences, and most importantly, a connection to a movement that is larger than their

\(^{12}\)Resource Mobilization theories have always recognized that social movements often have decentralized social movement organizations (Freeman 1975; Kriesi et al. 1995). Yet, they have historically downplayed the role of ideology (Buechler 1990, 1993; Dalton and Kuechler 1990). This is one of the reasons why I argue for a synthesis of these two theories to explain the alternative health care movement.
individual participation. The collective identity is one thread that connects these activists, and makes the movement appear large and cohesive to its challengers. Paying attention to a social movement predominantly outside the political arena enables us to document forms of movement activity that resource mobilization theorists have traditionally ignored.

We need to use a synthesis of both social movement theories to understand the alternative health care movement in its entirety. First, though it is primarily a fluid movement best explained by new social movement perspectives, resource mobilization theorists can better explain the role of collective organizations. Second, Gusfield (1994) argues that fluid movements tend to have little impact on or direct conflict with the state. Other scholars suggest the alternative health care movement is apolitical (Berliner and Salmon 1979:44; Mattson 1982:43). I argue that some alternative health care activists and their organizations do influence and engage political institutions. For example, I observed an interest group that attempts to change laws to ensure access to alternative health care techniques. Other groups and participants attempt to create personal changes in everyday life outside institutions, such as those involving lifestyle, diet and exercise. I argue that these informal strategies also have political consequences (Lichterman 1995; Taylor and Raeburn 1995). Social movements that focus on cultural elements such as the creation of alternative institutions do not necessarily lack legal and political aims (Taylor 1996). As Plotke (1990) argues, social movements are thoroughly political since they seek reforms and power. Political and personal changes are intertwined as the feminist slogan "the personal is political" taught us (Schlesinger and Bart 1982:151). Resource mobilization theory directly addresses the movement's explicitly political goals; whereas, new social movement perspectives can better explain the
personal changes the movement fosters. Finally, this theoretical synthesis follows a new line of research that brings cultural factors such as collective identity to bear on resource mobilization theory and structural or political factors into new social movement perspectives (Johnston and Klandermans 1995; Kriesi et al. 1992; McAdam 1994; Taylor and Whittier 1992, 1995). An understanding of both politics and culture is necessary to explain the new trend toward integrative medicine.

**Integrative Medicine**

I draw heavily on resource mobilization and new social movement theories to explain why the alternative health care movement has been able to pursue integrative medicine. I argue that changes in their opposition and the political opportunity structure have enabled activists to change their strategy over time away from pursuing an alternative medical model to developing an integrative model. I turn to institutional theories of organizations, though, to understand how Western medicine responds to this new challenge.

In many ways the authority and dominance of Western medicine are beginning to dismantle, and this has led to a more favorable political opportunity structure for activists within the alternative health care movement, as resource mobilization theory would suggest. There is an "apparent loss in a single decade of the authority that medical professionals held for much of the twentieth century" (Mick 1990:xiii). Overall, the medical environment is increasingly complex (Gray 1986:172). There is no longer a single, dominant group or figure in the medical industry; whereby power has moved away from the physicians to the medical schools, hospitals, health insurance companies, health care chains, financing and regulatory agencies
These groups have transformed medicine into a health care industry where profit, efficiency, financial managers and consumers take center stage. Even though this entails a gradual erosion of autonomy, physicians are more compliant now and less able to resist these changes. Most importantly, there is an increased supply of physicians so individual doctors lose their bargaining power (Gray 1986:174; Mick 1990:5; Scott 1993:279-80). Physicians are also more compliant due to the hospital's ability to hire and fire physicians, increased loans from medical education that make physicians look for job security in hospitals and HMOs as opposed to private practice, increased costs due to fear and prevention of malpractice, fewer hospitals where they can practice, and more alternative delivery systems that make physicians more attentive to patients' needs since they now have competition (Gray 1986:172, 174; Mick 1990:5-6). These political changes lead physicians, not just consumers, to take a closer look at alternative medicine.

Physicians turn to integrative medicine for a solution to the dissatisfaction they experience from their loss of authority, but also from their growing recognition that Western medicine has limitations. Physicians have learned that "nothing works universally." Though Western medicine is unsurpassed for acute traumas such as broken bones, Western drugs are not as effective with chronic illnesses such as back pain or arthritis (Mattson 1982:138). Some physicians have begun to see their techniques as only one method of healing patients. Other physicians turn to integrative medicine for a different way to practice. Though a minority, these physicians agree with holistic ideology such as the belief in education, empowerment and the

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13Hoffman (1989) argues that studying activist professional movements is critical since they are often opposed to change, we know little about internally generated change, and it represents a dynamic view of professions (4-5).
connection between the mind and the body. Speaking about a form of integrative medicine, Dr. Herbert Benson says “people are dissatisfied with routine medicine that’s strictly drugs and surgery, and here, now, is a way to incorporate value systems that people cherish [into medical practice] without sacrificing science” (as quoted in Baker 1997:20).

I show that activists change their collective identity as they begin to develop integrative models of medicine and influence Western medicine. Collective identities are not static, but continually evolving (Melucci 1995). Whittier (1995) examines how the collective identity of feminist changed as new participants, or political generations, entered the women’s movement. Her work outlines how the collective identity changes as women increasingly entered the movement during a hostile political climate. Taylor (1989) shows how feminists in the National Women’s Party survived the hostile period between the 1920s and the 1960’s. In contrast, I examine how collective identities change as the political opportunity structure becomes more open or favorable.

Taylor and Whittier (1992) argue that activists construct collective identities by creating boundaries, developing political consciousness and politicizing everyday life. To change institutions, activists have to continually negotiate boundaries between themselves and their opposition. Activists try to capitalize on political opportunities by loosening the boundaries of their movement and forming alliances with physicians. When activists pursue an alternative model of medicine they are competing with physicians and resisting Western medicine’s attempts to restrain their work. Now physicians are one of the key groups developing integrative medicine. Shifting the boundaries of who activists include within the movement affects the political consciousness of participants. Physicians move from the
opposition to a possible ally. Activists still politicize everyday life through personalized political strategies. Yet, they have new opportunities to influence Western medicine, insurance companies and the society at large through their associations with physicians. Alternative health care activists are willing to forge new relationships with their former opposition, since physicians can help the movement achieve a level of success previously unimaginable.

Activists are risking key elements of their collective identity to further their alliances with Western medicine, though. When some activists try to persuade businesses and insurance companies about alternative medicine, they emphasize results and cost-savings. Activists omit any mention of holistic beliefs even though they insist that they must maintain this ideology in practice. Other activists teach physicians about alternative medicine by describing a set of techniques. In this method activists risk divorcing the techniques from the ideology that shows how physicians should practice these techniques. It becomes easier for Western clinics to co-opt alternative techniques and leave behind alternative activists and ideology. Participants need to include physicians without losing control of the beliefs that have distinguished and unified their movement.

In this study I examine the possible outcomes of the movement's interactions with the institution of Western medicine even though social movement theory has remained virtually silent on outcomes, especially co-optation. Many theorists equate institutionalization with co-optation so I focus on this literature since I am interested in how the alternative health

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14 Social movement theorists who do examine outcomes include Gamson (1975/1990), Melucci (1989), Meyer and Whittier (1994) and Staggenborg (1995). In the conclusion I assess outcomes, or successes and failures, more generally; however, here I focus on how the social movement literature has examined co-optation.
care movement has gained access to Western medicine. Gamson (1990) examines outcomes in terms of gaining acceptance as a legitimate spokesperson for a set of interests, and acquiring new advantages for the group's beneficiary. In his model, co-optation means that a movement has gained acceptance without the accompanying advantages such as policy changes. An example from the alternative health care movement would be where administrators allow a yoga instructor to work in a hospital, but the patient's insurance coverage does not reimburse this service. Garner (1996) suggests that institutions co-opt movement participants by allowing them insider status within existing institutions, but restricting their work to "a limited set of reforms" (35). In this case the hospital may allow the yoga instructor to request that physicians send their patients to her class, yet she may not be able to demand that physicians change their medical practices to recognize the connection between the mind and body. Kriesi and his co-authors (1992) suggest that informal co-optation takes place when elites facilitate a movement, but do not grant them formal access to their institutions. For example, Western medicine does not allow most alternative practitioners to practice within hospitals, but physicians may refer patients to their clinics. This is similar to McCarthy and Wolfson's (1992) definition of co-optation, which is when a movement uses a group's "resources for purposes other than those for which they were originally created" (282). A nurse may use the hospital's copier machine to reproduce movement literature, for example. In Kriesi's definition, elites purposefully facilitate a movement; whereas, McCarthy and Wolfson's scenario includes activists who co-opt the elite's resources without their knowledge or consent.
The social movement literature has examined a movement's interactions with elites more generally, though theorists do not always specify the outcomes such as co-optation. Resource mobilization theory is more useful than new social movement theory, since the former examines how movements interact with political actors. Both strands of resource mobilization theory, the organizational-entrepreneurial and political process model, argue that movements need elite support for societal legitimacy and political leverage (Barkan 1979, 1984; Jenkins and Perrow 1977; McCarthy and Zald 1973, 1977). Theorists disagree as to what role elites play specifically (Staggenborg 1991:153). The organizational-entrepreneurial model argues that elite support is necessary prior to movement mobilization (Jenkins and Perrow 1977; McCarthy and Zald 1973, 1977; Zald 1988). Elites act as conscience constituents, or those who are sympathetic to a movement, by providing resources necessary for mobilization (Freeman 1979; McCarthy and Zald 1977). Proponents of the political process model, on the other hand, suggest that elites support a movement only after grassroots mobilization has occurred (McAdam 1982; Morris 1984; Staggenborg 1991). Political process theorists also warn that elites have a vested interest in maintaining the status quo, so they may use their participation as a way of controlling or restraining a movement's mobilization potential (Gamson 1968; Jenkins and Eckert 1986; McAdam 1982; Oberschall 1973). Elites may force activists to pursue more moderate goals or tactics simply by threatening to withdraw support (McAdam 1982; McCarthy and Zald 1987; Piven and Cloward 1977). Given

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15 Zald and McCarthy (1987) contrast constituents, or those who provide resources for a social movement, with adherents who share movement beliefs and beneficiaries who gain from movement goals.

16 Some social movement theorists argue that movements do not always become more moderate with elite support (Jenkins and Eckert 1986; Zald and Garner 1987). Jenkins and Eckert (1986)
that elites probably have multiple or complex reasons for assisting social movement actors, both scenarios described by the organizational-entrepreneurial and political process models are possible (Jenkins and Eckert 1986:815). I agree with theorists who argue that elites can constrain, control or aid a social movement (McAdam and Snow 1997:365; Oberschall 1973:65).

Much of the resource mobilization literature focuses narrowly on monetary support, yet elites may also participate in a social movement. Some women pursue a feminist agenda within their professional careers as lawyers, professors and physicians (Taylor 1996; Whittier 1995). Feminists, along with activists in other movements, also work toward movement goals using established bureaucratic channels within the government (Eisenstein 1995; Halcli and Reger 1996). Santoro and McGuire (1997) identify movement participants who work within the government specifically as "institutional activists." These studies are important because I show that physicians are now joining the alternative health care movement and pursuing integrative medicine.

Some theorists acknowledge that social movements are never complete insiders or outsiders (Staggenborg 1991:6; Tarrow 1989:18); however, few explain a movement's interactions with institutions as a dynamic process. Much of this literature assumes that social movement organizations become co-opted over time (McCarthy and Zald 1973, 1977). Theorists and activists often equate this co-optation with a loss of mobilization, protest and militancy. In other words, theorists view co-optation as an inevitable, but one-directional linear model of change (Lowenberg 1989:232-233).

think channeling is a better metaphor than "control" or "co-optation" for looking at elite patronage, because they find that elites affect movements in more subtle and indirect ways (812, 828). For example, they found that elites did not change the movement's goals or tactics significantly, but did contribute to organizational changes and a decline in mobilization.
We also see this problem in the institutional literature, though now the established organization is the passive actor. Selznick (1948) argues that an organization co-opts or "absorbs new elements into their leadership or policy" (34). An organization may bring a competitor onto the board of directors in order to win their consent, power or resources. He views co-optation as a defensive mechanism of organizations to maintain stability. In Selznick's study the Tennessee Valley Authority allowed outside constituencies to modify their programs in exchange for their ability to preserve these programs. Pfeffer and Salancik (1978) confirm that organizations use co-optation when an interest group is "politically potent" (167). Likewise, "new" institutional theories suggest that established organizational fields are homogeneous because each organization has to concede to environmental pressure to remain stable (DiMaggio and Powell 1983; Meyer and Rowan 1977).

Movements inevitably change when they interact with existing institutions, and the reverse holds true as well. Activists may modify their discourse to appear more acceptable to elite sponsors (Jenkins 1981; McAdam 1982); however, I argue that social movements can resist co-optation of their ideas or personnel, even when activists gain access to elites and institutions. I also argue that established organizations can actively respond to external demands. Oliver (1991) develops a typology of organizational responses using institutional and resource dependence perspectives. The latter suggest that organizations stabilize by exercising power or control over, or negotiating with, external threats (Pfeffer and Salancik 1978). She argues that organizations can acquiesce, compromise, avoid, defy or manipulate external threats. In all five types of interactions, external groups influence and affect institutionalized organizations in some way. A hospital may study the
connection between the mind and the body once administrators have allowed an alternative practitioner to join the staff, for example. Institutional theories rarely inform social movement theory, but I find it necessary to use both to examine the institutionalization of alternative medicine as a dynamic process.

The alternative medical model activists developed in the beginning of the movement is vastly different from the integrative model they are now creating with physicians. This new strategy signals a political openness toward alternative medicine. What activists do with these opportunities is an empirical question. Activists may no longer be “voices in the wilderness,” as one of my respondents puts it, but the future of medicine and the alternative health care movement remains unclear. In this study I use social movement theories to document the dramatic successes of the movement, and institutional theories to specify possible responses by their opposition.

**Chapter Outline**

In the following chapters I outline the dynamic relationship between a social movement, the political opportunity structure and a movement’s opposition as activists interact with the institutions they seek to change. In chapter two I discuss my research methods. The third chapter describes alternative techniques and beliefs, which is the way most theorists perceive alternative medicine. In contrast I argue that alternative medicine is a social movement. An important component of movements is the oppositional identity that activists construct and maintain. I focus heavily on the beliefs in chapter three because they are a key element of the collective identity that I

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17Minkoff (1995) is an exception in her study of women’s and racial-ethnic organizations in the United States.
begin to address in chapter four. Also, the strength and persistence of these beliefs allow the movement to prevent Western medicine from co-opting their personnel and techniques. In chapter four I describe the collective identity of activists pursuing an alternative medical model. These activists draw boundaries between participants and outsiders based on who is more likely to use and practice alternative medicine. They develop a political consciousness by helping participants turn their individual discontent with Western medicine into a structural critique. Activists engage in personalized political strategies such as choosing alternative medicine as consumers and transforming the workplace as practitioners. I use the concept of collective identity to show how participants turn their experiences with alternative medicine into activism and collective action. In chapter five I turn to the institutional context where the new trend toward integrative medicine has emerged. This includes the crisis in Western medicine due to financial and organizational changes, as well as the resulting attack on medical authority. After I describe the features of integrative medicine, I show how participants are changing their collective identity. Since activists have begun to include physicians within the movement, their political consciousness now critiques the way physicians practice medicine not Western tools such as drugs and surgery. They are also expanding their strategies to include educating physicians, insurance companies and businesses as they gain more access to Western medicine. I describe new areas of conflict that emerge as the collective identity changes. For example, power differences that exist between physicians and alternative practitioners hamper the success of an integrative model of medicine. The final chapter summarizes my theoretical conclusions about why alternative medicine is a social movement, how a social movement’s collective identity changes over time due to shifts in the
political opportunity structure, and what the possible outcomes are as the movement attempts to become institutionalized. I also suggest ways to apply my theoretical model to other social movements that interact with the institutions they seek to change.
<table>
<thead>
<tr>
<th>WESTERN MEDICINE</th>
<th>ALTERNATIVE MEDICINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The focus is on disease and limitations.</td>
<td>The focus is on health and self-control.</td>
</tr>
<tr>
<td>Focus on how all patients with an illness or symptom are similar.</td>
<td>Focus on individual uniqueness despite similar illnesses or symptoms.</td>
</tr>
<tr>
<td>Disease is caused by an invasion of the body by outside agents such as germs.</td>
<td>Disease is caused by a distortion of the self-healing and self-regulating systems in the body.</td>
</tr>
<tr>
<td>Diagnose through observation and medical tests.</td>
<td>Diagnose through subjective evaluations of clients.</td>
</tr>
<tr>
<td>Diagnosis identifies the causative agent.</td>
<td>Diagnosis identifies life factors.</td>
</tr>
<tr>
<td>Control or eliminate symptoms in order to manage disease.</td>
<td>Restore the homeostatic balance in the body in order to eliminate disease.</td>
</tr>
<tr>
<td>Drugs and surgery are used to suppress or eliminate symptoms.</td>
<td>Drugs and surgery are avoided since they further disrupt homeostasis.</td>
</tr>
</tbody>
</table>

Source: Adapted from Coulter in Sobel 1979:294; Lowenberg 1989:34; Mattson 1982:49, 126-7; and Weiss 1984:141-2

Table 1.1: Partial Comparison of Western and Alternative Medicine
CHAPTER 2

METHODOLOGY

Theoretically, this study examines how social movements interact with their opposition over time. Though I am turning to social movement theories to explain this dynamic process, I extend these approaches by using institutional theories to show how a movement and its opposition change as activists attempt to institutionalize their goals. This study also adds empirical data to our understanding of alternative medicine, which is an understudied phenomenon, especially as a social movement.

To pursue these theoretical and empirical aims, I conducted an ethnographic study of the alternative health care movement in the San Francisco, California Bay area. Numerous scholars and advocates define this location as the center of activity for the alternative health care movement (Berliner and Salmon 1979). The research is based on interviews, participant observation and secondary analysis of movement and clinical documents. First, I conducted formal and informal interviews with practitioners, clients and activists. Second, I observed three alternative clinics, an interest group and a professional organization. Finally, I examined movement and clinical literature to aid my understanding of the local movement.

I did the majority of my interviews and clinical observations in Marin county, north of San Francisco. There are several reasons why most of my respondents worked in this area, and why one chiropractor defined Marin
county as the holistic health care capital in the Bay area. First, much of the alternative health care movement started here. One of the first alternative health care clinics is in Mill Valley, a town situated a few miles north of San Francisco. Second, many residents hold ideologies that make them receptive to alternative health care. Paul Ray (1996) labels a new group of individuals "cultural creatives". Ray suggests that cultural creatives may be more prevalent in Marin county since "Marin is more innovative culturally than the rest of the country...we're trendsetters" (Ray as quoted in Liberatore 1996:A7). Cultural creatives believe in a set of values that include environmental and women's issues, as well as alternative health care. They believe they can heal society through healing themselves. Ideologies such as these often translate into receptivity for alternative health care. Believing in holistic health, cultural creatives spend more money on alternative medicine than others. Finally, Marin county has the eleventh highest median family income in the United States, and the highest in the San Francisco, Bay area. Marin families earn $59,157 compared to the national average of $35,225. It is no coincidence that a lot of movement activity takes place there today, because most individuals must pay for these alternative techniques out-of-pocket. Insurance companies typically do not reimburse individuals for using alternative health care. Consequently, middle to upper income clients are much more prevalent.

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1 Ray (1996) compares these cultural creatives to heartlanders and modernists. The former have a "Midwestern sensibility" while modernists see the body as a machine that they can ignore until it breaks down (15). Cultural creatives are more likely to be middle to upper class, female and residents of the West coast. Numbering 44 million, or 24% of the adult population, they are connected to a broad social movement that contains spiritual, New Age, ecology, women's, humanistic psychology and alternative health care elements.

2 Based on 1990 Census data. Please see Table 2.1 for a list of the eleven counties with the highest median family income in the United States.
I examined the grassroots level due to the movement's decentralized nature (Johnston et al. 1994). The alternative health care movement does not have one identifiable or central organization that unifies the entire movement. Rather, diverse clinics, activist organizations and individuals comprise this diffuse movement. More than their organizations, alternative health care movement participants are connected through their ideology that they promote through written material and interaction (Gusfield 1994). This ideology allows diverse and often disconnected individuals to have shared meanings, similar experiences, and most importantly, a connection to something larger than their individual participation.

It is also important to study the movement at the grassroots level, because a large portion of a participant's activism is embedded in everyday actions and interactions (Gusfield 1994; Taylor and Whittier 1992). For example, some participants define advocating lifestyle changes, or putting the ideology into practice, as a form of activism. These are “action[s] taken with the recognition that it is not isolated and individualistic” (Gusfield 1994:66). Many participants perceive their actions as activism that is connected to something much larger. Studying the alternative health care movement at the grassroots level enables me to explore these connections between individual actions and a larger movement.

DATA

These data address two research questions. First, I conducted interviews, observed several activist organizations and collected clinical documents to describe the alternative health care movement in the San
Francisco, California Bay area. Second, I examined how the newer trend toward integrative medicine is developing through additional interviews and observations.

INTERVIEWS

First, I interviewed forty alternative practitioners and clients. I use these interviews as my primary source of data. I compiled a list of alternative clinics in the Bay area through previous literature and the local telephone directories. I telephoned clinics to obtain volunteers. Most of the individuals I interviewed were practitioners. Consequently, I used snowball sampling to gain access to additional respondents, many of whom were clients. I also gained access to two respondents through a flyer I had posted in various alternative clinics. Of the forty respondents, thirty (75%) were alternative practitioners; whereas, ten (25%) were clients of alternative techniques only.\(^3\)

I conducted interviews either on the phone or in person, at the respondent’s request. If I conducted the interview in person, I had respondents sign a consent form and fill out a demographic sheet. I mailed the consent form and demographic sheet to respondents if I conducted the interview by phone. I typically asked respondents whether or not I could tape the interview. Every respondent I asked consented. I transcribed all of the data from these interviews myself, verbatim and in their entirety.

\(^3\)Two of the ten clients were in training programs to become an alternative practitioner, but had not finished.
Overall, respondents were overwhelmingly female (73%) and Caucasian (97%), and ranged in age from 35 to 63 (mean age=47). All respondents had taken some college courses, and 71% finished some graduate work or received graduate degrees. Religious or spiritual affiliation varied greatly, though 26% said they had no affiliation whatsoever. Forty-two percent of respondents are currently married, though an additional 33% were previously married. Finally, respondents did not report their incomes accurately enough to ascertain a reliable range or mean. Only 50% of the sample gave enough detail to provide the following information. Of those twenty respondents, they earned anywhere from $18,000 - $80,000 last year (mean income was $41,980). Of those not included in the range or mean, however, one respondent said he made “six figures”, one reported an income of only $3000, and another earned $8568 on disability.

Since this is exploratory research, I focused my research questions as the project progressed and varied my interview questions accordingly. Interviews were not standardized so respondents did not answer an identical list of questions (Fowler and Mangione 1990:18). First, my interviews with the practitioners in each of the three clinics I observed were much more focused on the clinic as a whole. I asked more questions about funding, structure and interactions with other practitioners than in the other interviews. Second, I conducted interviews with members of a professional organization developing models of integrative care. I asked questions more focused on this organization, their definitions of integrative medicine and where they see this trend developing.

These percentages do not always represent all 40 respondents I interviewed, because some did not respond to every question.
In the beginning I conducted interviews to address my first research question on the alternative health care movement in the Bay area. I began these interviews asking respondents about their definition of alternative health care, what alternative techniques they had tried and why, and how people respond. At this point in the interview I also asked whether or not they feel connected to an alternative health care movement or any other social movement. If they did identify as an activist in the alternative health care movement, I asked them to describe their activism. If they are involved in other social movements I asked whether there was any connection between that activism and their involvement in the alternative health care movement. Then I asked respondents to tell me what differentiates an alternative health care clinic from a Western medical clinic. I also asked whether or not they still obtained services from Western medical doctors. Regardless, I asked them to describe their previous experiences within Western medicine. I then asked different questions of practitioners and clients. First, I asked practitioners to discuss why they decided to become a practitioner of alternative techniques, what training they have had, and what services they provide. Then I turned to their work more specifically. I asked them to describe their clients. For example, are clients more likely to be women or men, and if so, why? I also asked why their clientele seek their services, and whether clients compare their alternative clinics to Western medicine. Second, I asked clients to describe who they see waiting for the alternative practitioners they use, and to compare their experiences within alternative and Western medical settings. I closed the interview asking both practitioners and clients about the direction they believed alternative medicine was taking as a social movement, as a set of techniques, and as a core set of beliefs.
In the latter stages of my interviews, I talked primarily with staff members of each of the three clinics I observed. These interviews focused more narrowly on their work within the clinic. To illustrate, I asked about issues ranging from the clinic's goals to their successes and failures. I include most of these data when I discuss my observations, because it helps to paint a complete picture of each of the three clinics I describe.

I concluded this phase of the research when I found that the information respondents provided was redundant with prior interviews, and staff members addressed all aspects of their clinics where observations took place. Qualitative researchers identify this as saturation and define it as the point when "the researcher stops learning new things about the case and recently collected evidence appears repetitious or redundant with previously collected evidence" (Ragin 1994:86-87).

In the latter stages of my research I conducted interviews to answer my second research question on integrative medicine. Most importantly, how is this trend developing? Why are physicians interested? Do activists experience conflicts now that their collective identity is changing? I interviewed members of a professional organization developing models of integrative care. I began these interviews by asking members to define integrative medicine, describe how they became affiliated with the organization and why, and to explain some of the advantages and disadvantages of the group. For example, I asked about interactions between physicians and alternative practitioners, the motivations of other members in the group and whether they were learning new information on other alternative techniques. Since I had just attended a two-day professional symposium sponsored by the group, I asked members to reflect on the event. I ended the interviews by asking members how they thought integrative
medicine will develop in the near and distant future. I had a particular interest in whether they thought physicians and alternative practitioners could remain as equals or whether physicians would co-opt alternative medicine.

PARTICIPANT OBSERVATION

Researchers gain direct access to the ways insiders create meaning, construct identities and create communities through the method of participant observation (Jorgensen 1989:14-15; Lichterman 1996:240). To do this, the researcher must be directly involved with the group under study. Most groups will not reveal their actions and meanings unless someone is willing to become a member. Ideally the researcher is able to see as many perspectives as possible within the group. This is accomplished through a combination of observation and participation. As I found in my research, it is difficult to observe without participating. "People have a tendency to involve you" (Jorgensen 1989:58). As Jorgensen (1989) argues, this indicates your acceptance into the group, however limited it may be (58).

After I completed the majority of my interviews, I observed three types of alternative clinics; a feminist women's clinic, a solo practitioner sharing office space with other alternative practitioners, and an integrative clinic that combines Western medicine with alternative medicine. In each case I gained permission from the Director or owner, and had them sign a consent form. All three clinics are located in Marin county, north of San Francisco. Observations varied depending on the type of access I was allowed and the amount of information I needed. In one clinic I talked with staff members
and informally observed the setting and interactions while waiting for these appointments. In the other two clinics I observed in the waiting room and interviewed clients before or after their appointments.

During the observations, I was looking for very specific information on the setting and interactions to add to my understanding of the movement based on the interviews. In addition to the primary purpose of seeing how these clinics were different from Western clinics, I obtained data on each of the clinic's emergence, clientele, staff, services, ideology, structure, tactics, funding, interactions, collective identity, goals, outcomes and cultural factors (e.g., symbols and discourse). Since I was able to interview so many staff members in each clinic, I did not need to observe more than a few times at each clinic to gain the necessary information.

In addition to the three clinics, I observed an interest group and professional organization. Though I helped the interest group plan a health fair, participants knew about my role as a researcher. The director of the professional organization gave me permission to videotape their symposium. My observations of the three clinics and interest group addressed my first research question to describe the alternative health care movement. My observations of the professional organization and one of the clinics enabled me to answer my second research question on integrative medicine. Observations of each organization play a lesser role in my research than interviews with members of each.

I did not experience the typical problems associated with participant observation. First, I did not have the dilemma of whether or not to tell participants about my role as a researcher. My involvement was overt since all insiders knew the purpose of my participation (Jorgensen 1989:21). Clinic directors told clients and staff, in advance, that I was a researcher interested in
the alternative health care movement. The clinic directors made sure I observed on days where my presence would not threaten clients. The local organizer of the activist group also told organizers and participants about my research. I also shared this information with any new people I met. I looked like a participant at the symposium sponsored by the professional organization since I videotaped the event, so I always told those in attendance that I was a researcher. Second, since this phase lasted only a few months, and since I was never a participant in the full sense of the word, I did not have problems becoming too involved in the organization or clinic (Jorgensen 1989:62). I think this was because I never fully immersed myself in one organization or clinic. To illustrate, I observed some clinics simultaneously, and none of my observations lasted more than ten hours at a time. I was always able to go home, take notes and discuss my findings with others. No matter how long I had spent in the field, I always remained an outsider who "move[d] on in ways quite different from those studied" (Van Maanen 1982:145).

Since I observed five diverse organizations, I differentiate between clinics, interest groups and professional organizations. The clinics are service-oriented since clients consult practitioners in these settings for advice and treatment. The primary task of practitioners is to deliver health care, even though they also educate and empower clients. The interest group focuses on educating and lobbying, rather than providing services. This particular organization has a professionalized national organization with decentralized local organizations. The interest group is similar to a "federated" social movement organization in that the national and local organizations share a common mission, and the national organization provides direction and assistance with grassroots activism (McCarthy and
Zald 1977). However, it is different from a federated social movement organization since local members do not participate in decision-making. The professional organization is similar to any group of professionals that form an organization to educate members and advocate on their behalf. While lawyers have the American Bar Association and physicians have the American Medical Association, this professional organization contains both alternative and Western practitioners. Members educate each other and advocate integrative medicine. Even though clients periodically attend case conferences on specific illnesses, the practitioners do not deliver services to these clients within the confines of this organization so it is not service-oriented.

Feminist Women's Clinic

Ten years ago, the clinic opened as a birth center that secondarily offered gynecological services. The birthing side of the business closed in 1996 due to the decreasing coverage and increasing costs of insurance. So they made the gynecological services the main focus of the clinic. Their services include pap smears, breast health, birth control, blood chemistry tests, perimenopause and menopausal counseling and treatment, testing, abnormal pap smear treatment (e.g., using anti-oxidants), nutritional counseling, vaginitis treatment, testing for HIV and other sexually transmitted diseases, and uterine alignment with the cervix. Exams offering these services range from forty-five to ninety-five dollars.

This clinic has a spiritual center that works in collaboration, not competition, with the clinic. As a compliment to the physical exam, the nurse practitioner offers a spiritual healing to women who have gynecological exams. They base this service on the ideology that health and
well-being entails not just the physical body, but the emotional, mental and spiritual well-being of the individual. In addition to these spiritual healings, the spiritual center offers readings with clairvoyant counselors, hands on healings, an energy check, transmedium healings, use of psychic tools and foot anointing. The spiritual center is open to men, women and families. Approximately 25% of the clients are men. The profit from the spiritual center supports the women's clinic.

The spiritual center borrows much from Christianity even though healers "respect other religions." Their written literature and artwork refer to the bible. Members call the center a church, and ordain ministers and bishops for service within it. Several of the brochures contained the following scripture: "it is sown a natural body. It is raised a spiritual body. There is a natural body and there is a spiritual body" (1 Corinthians, 15-16). On one of their advertisements they refer to Matthew 16:19 even though they do not include the words from the literal scripture. This advertisement refers to a laying on of hands healing service so it is interesting that this passage refers to the basic Christian confession of faith that Jesus is the Messiah. One of their lecture series pertains to Jesus' second coming (December 1996/January 1997 newsletter). In the waiting room there was a stained glass picture of the Virgin Mary.

The director says that even though the religious basis of the center is "not that important to us," the practices are critical. Members and practitioners recognize the connection between spirituality and health. For some individuals there is a causal relationship between the two. The director says that the illnesses of some people are a "physical manifestation of a spiritual dilemma." Other individuals find spirituality appealing given their health concerns. The director finds that some members look inward for
spiritual healing, because health care practitioners have not provided "good explanations" for their illnesses. This confirms research that finds many people turn to religion or spirituality after illness. For example, most people that have had a near-death experience have a new spiritual curiosity though they often begin to eschew religious doctrine and tolerate spiritual diversity (Moody 1988:27, 39; Ring 1980:185).

This clinic is different from integrative clinics that I will discuss next. Even though the nurse practitioner offers Western medicine where appropriate, their clientele typically choose alternative medicine exclusively. The feminist clinic also focuses on services for women, and adheres to feminist ideology.

**Integrative Clinic**

The integrative clinic combines allopathic and alternative medicine based on the belief that both types of medicine serve a purpose and have a place in patient care. Its goal is to provide "comprehensive health care that works better than any one approach by itself" (clinic flyer). Rather than just referring clients to other practitioners, they coordinate "these approaches in a way that will bring quicker and longer lasting results." The director explains that "there is a synergy that can happen. It's not just a matter of 1+1=2. It can sometimes equal a lot more. If you can integrate your efforts, you can get much better results."

I observed an integrative clinic that provides clients a range of techniques. Their services include acupuncture, homeopathy, herbology, internal and family medicine, women's health, non-force chiropractic, bodywork, Yoga, pain management, psychotherapy, lifestyle guidance, nutritional counseling, biofeedback, and movement re-education.
addition, their staff offer preventive, internal and sports medicine; menopause, gynecological conditions and infertility treatment; neurolinguistic programming; and clinical hypnotherapy. Since there has been some turnover, this range of services varies over time.

Briefly, their clientele have a broader range of conditions, ideologies, and willingness to try different techniques. A minority of clients are drawn either by allopathic or alternative medicine, and use these techniques exclusively. For example, some clients only request Western techniques such as a yearly gynecological exam. Practitioners refer to these individuals as "allopathic patients." The majority of clients have a condition and are open to various techniques. For example, someone with acute back pain may be willing to try anything from pain management through Western drugs to acupuncture or movement re-education. It is an advantage for this latter group of clients to obtain all of their medical care in the same location and know that their practitioners are consulting each other. This broad range of clientele enables the integrative clinic theoretically to have more clients than a clinic that focuses exclusively on allopathic or alternative medicine.

Practitioners pay rent^ and keep the entire amount they collect from clients. The integrative clinic is different from solo practitioners sharing office space, though, because practitioners advertise under one collective name and act as a team.

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^Their rent covers the examining "room, phone, some of the furniture, all the reception assistance [and] building liability." They have their own malpractice insurance. They bill clients themselves, except if a client is "using a credit card for a co-pay or a visit then [the front desk] provides that service." The clinic will advertise for the practitioners since they act as a team, but some practitioners would like to do some more on their own. They need approval from the co-directors for any advertisements since it has their collective name on it.
Solo Practitioners Sharing Office Space

There are numerous examples of alternative practitioners who have individual practices, but share office space with other alternative practitioners. Typically, these alternative practitioners choose to work next to other alternative practitioners. They can share knowledge, clinical advice and referrals with these other practitioners. These arrangements vary as to structure, funding and cohesiveness. For example, some groups refer back and forth, and meet with each other about these clients. Other groups simply pay rent separately, and have no further contact with the other practitioners.

To understand this type of alternative clinic, I observed a solo practitioner practicing acupuncture and Traditional Chinese Medicine (TCM) that shares office space with other alternative practitioners using various forms of bodywork. The acupuncturist owns the office, and rents space to these other practitioners. Rather than firing a practitioner, she would simply terminate his or her lease. She did not choose this particular office in order to have this type of arrangement, but she says it probably would have been a long-term goal to bring in other practitioners. Ideally, she will bring in a chiropractor to the group.

Each practitioner has an independent business. They have individual phone numbers, and make separate appointments. Other than paying rent to the acupuncturist, each practitioner gets to keep the money collected from clients. Practitioners will refer clients between modalities, but they do not have formal conferences on these clients. At most, they discuss the client informally after his or her appointment. The acupuncturist stated that less than half of her clients would also see a bodyworker in the office. If they do, many just use these bodywork techniques for short-term acute injuries.
This acupuncturist views herself as a general practitioner; whereas, other acupuncturists may specialize. She has approximately two hundred regular clients and three hundred who come only when they have symptoms. A client would usually see her once a month for prevention or health maintenance, which describes why half of her clientele come to see her. The other half have a variety of health problems from headaches to gastrointestinal problems.

Interest Group

The interest group has 170 chapters in all fifty states and fourteen foreign countries. I observed one local chapter plan and execute a one-day health fair and workshops to raise awareness about alternative techniques and money for their organization. My research sheds light on local activism that fits the focus and strategies of the national organization. Trying to raise awareness about alternative techniques, the event’s goals included education and lobbying in addition to the stated purpose of fundraising. The all-day activities included celebrity speakers, a health fair where visitors could learn about and try alternative techniques ranging from chiropractic to Reiki, and workshops on general wellness, women’s health issues, and children’s nutrition. Several hundred people attended the health fair and lectures.

Participant observation entails the researcher becoming directly involved, because most organizations will not allow an outsider to have inside information without participating in some way (Jorgensen 1989:58). In order to study this social movement organization, I joined the national organization and organized publicity for this fundraising event. Interestingly, I was first approached by the local chapter after I had left a message at an alternative clinic for one of individuals I had interviewed. The main event
organizer is in a training program at this clinic. She had heard my message describing enough about my research that she called me to become involved. Though I originally wanted to participate minimally in this organization, very quickly I became involved to a greater degree as there was a lot of volunteer turnover. Thus, my first experience with the organization was as head of publicity for the fundraising event. This confirms Jorgensen’s (1989) argument that insiders tend to involve researchers in the work of the organization (58).

My observations occurred during these organizing stages, as well as at the event. Before and after this event members were not as active so I was unable to maintain contact except for the monthly national newsletters. Since my observations revolved solely around this event, these observations are less central to my attempt to describe the local movement. Consequently, I only use these as a supplementary source of data.

Professional Organization

Finally, I observed a professional organization devoted to integrative care. Several physicians started the group, and one acts as the director. Within a year and a half it had exploded to nearly 200 members, consisting of physicians, alternative practitioners and a small number of lay people (e.g., health care entrepreneurs). In one newsletter they said the group consisted of over 60 physicians, 15 chiropractors, 3 veterinarians, 20 psychologists, 8 dentists, 13 nurses, 10 acupuncture and oriental medicine professionals, 4 naturopathic practitioners, 3 osteopaths, 20 body work practitioners and several nutritional educators.
Most of the monthly meetings revolve around education and awareness. Speakers discuss a variety of topics from nutrition to how to generate income by focusing on preventive health care. They also educate through a monthly newsletter. For example, they include highlights from the speakers and advertisements in these issues. They spent the first eighteen months trying to understand and educate each other. This process was extremely difficult since practitioners typically have a different ideology, set of guiding assumptions and language underlying their work. This dialogue culminated in a two-day professional symposium on integrative medicine during June 1997.

I started observing this group while they were in the final stages of planning this symposium. Their goals were to establish communication and understanding between diverse professionals, Western and alternative, explore the benefits to patients and providers of integrated care, learn how to view the whole patient, and make the shift from disease care to health care. They organized speakers according to whether they examine psychological, physical, biochemical or energetic components of the body and healing. Approximately 125 participants attended the symposium, though it is unclear how many were not connected to the group directly.

In addition to observing and interviewing members, I videotaped the symposium (Jorgensen 1989:22). An anthropologist studying this organization also gave me videotapes of eight monthly meetings, six leading up to the symposium and two following it. Consequently, I have information on this group’s activities from January through September 1997. Van Maanen (1982) includes filming as an ethnographic strategy (103).
**Documentary Data**

Finally, I conducted secondary analysis of movement and clinical literature to increase my knowledge of the local movement (Jorgensen 1989:22). These include newspaper and magazine articles, activist newsletters, event announcements, position papers, and clinic handouts describing services. This was not a random sample, nor were these documents representative of the movement as a whole. Rather, they helped me understand what was happening on a national level and locally within the San Francisco, California Bay area. I examined articles from sources as diverse as *Alternative Medicine Digest* to *TIME*. I cite all documents throughout the text. Many of these documents allowed me to see how prevalent alternative medicine was, especially in mainstream sources. I did not limit these sources to published material, because I was also interested in literature that would be given to individuals who were already patients of alternative clinics or advocates of alternative medicine. Though not a primary source of data, I used these data to supplement information from the interviews and observations.

**DATA ANALYSIS**

I focused and specified my theoretical framework over the course of the project. I began with the broad goal of using social movement theories to explain the success of the alternative health care movement. This entailed examining the movement's participants, goals, strategies and outcomes. For example, I describe why women are more likely to be consumers and practitioners. In the process of collecting data, I began to see a new trend
toward integrative medicine. I focused my project to extend current social movement theory by examining why this strategy was possible, and how this new direction changed participants and institutionalized medicine.

I analyzed the data using inductive and deductive methods. I used social movement theories to identify broad categories that guided my initial analysis. I coded the interview transcripts and notes on observations and documents into these broad categories, such as "recruitment," "strategies" and "ideology." I then identified specific themes within these categories, such as the "importance of activism to individuals," "empowering clients" and "individual responsibility for health." Finally, I drew theoretical conclusions within each category based on common findings and themes that emerged.

I present the analysis with enough detail to show what people said without risking their confidentiality. I have not identified respondents by name or used any information that would disclose their identity. Though this means I need to omit some information that the reader may find helpful it is necessary to preserve their anonymity.

**SUMMARY AND LIMITATIONS**

The combination of interviews, participant observation and documents provides an overview of the alternative health care movement in the San Francisco Bay area. Since there are no central organizations that unify the entire movement, I have tried to capture the diverse organizations, individuals and identities that comprise this diffuse movement. It is also important to study the movement at the grassroots level, because much of a participant's activism is embedded in everyday actions and interactions.
This study has certain limitations. First, I was not able to interview or observe all of the various individuals and organizations within alternative medicine. Since there is so much diversity and activity in the Bay area, I aimed for a broad picture of what is happening. This means that there are obvious oversights in terms of specific types of alternative medicine. One particular oversight is in the area of lay healers. I compiled my sources through phone directories, previous literature, and snowball sampling techniques. This produced a list of professional healers or practitioners. Obviously this misses the lay healers who do not advertise or are not known outside their local communities.

Second, the study is limited in terms of the region of the country where I conducted the research. I chose the San Francisco Bay area for the amount of activity, and because many suggest that trends start on the West coast and then filter to other places. Yet, questions of generalizability arise. How typical are the experiences of people in the Bay area? How representative are alternative clinics in this area? We need a national study to answer these questions. To counter this limitation, I referred to studies from other cities and states to compare my findings (Eisenberg et al. 1993; Kleinman 1996; Otto and Knight 1979; Salmon 1984; Schneirov and Geczik 1996). This helped me to gauge that alternative medicine is gaining popularity in most parts of the country, especially urban areas. Only a national study could illuminate regional differences. Before I examine the movement in the Bay area, I define alternative medicine in the next chapter.
<table>
<thead>
<tr>
<th>County</th>
<th>Median Family Income</th>
<th>Rank</th>
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<tr>
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<td>1</td>
</tr>
<tr>
<td>Morris (New Jersey)</td>
<td>$62,749</td>
<td>2</td>
</tr>
<tr>
<td>Somerset (New Jersey)</td>
<td>$62,255</td>
<td>3</td>
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<tr>
<td>Falls Church (Virginia)</td>
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<td>Hunterdon (New Jersey)</td>
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Table 2.1: Counties with the highest median family income in the U.S.
CHAPTER 3

DEFINING ALTERNATIVE MEDICINE

There is a wide range of definitions for alternative medicine in the popular and scholarly literature. This lack of coherence and agreement makes it difficult to discuss alternative health care in its entirety and allows for a great deal of diversity within this category. For sake of simplicity, some researchers define alternative medicine residually as any type of medicine or treatment that is not Western or allopathic (Wardwell 1994:1061), or not in conformity with Western medicine (Gevitz 1988:ix). One male client in my study says, "basically it seems to be the things that are not taught or covered by Western medicine."

It is more useful to specify alternative medicine based on its characteristics, rather than define alternative health care by what it is not. Social scientists that help us with this specification can be divided into three main groups. They use the terms "alternative health care" and "holistic health care" as umbrella terms that refer to a group of clinical techniques, core set of beliefs or a social movement (Lowenberg 1989). In this chapter I explore the first two conceptualizations. I focus heavily on the ideology since these core beliefs help the alternative health care movement unite activists and prevent co-optation of their techniques and personnel. This leads into my
argument in the next chapter that it is most useful to conceive of alternative medicine as a social movement, and visualize these beliefs as a core part of the movement’s collective identity.

**ALTERNATIVE TECHNIQUES**

First, some lay people and researchers identify alternative health care as a group of clinical techniques like acupuncture, which receives media attention. Commentators on national shows are increasingly exploring some of these techniques. For example, hosts on the show *Good Morning America* ran a segment on the “mainstreaming of alternative medicine” where they described an explosion of interest in alternative health care within the last ten years (ABC: 6/25/96). Commentators on the show *Turning Point* asked whether alternative medicine was “hope” or “hype” (ABC: 9/26/96). Also, media personalities are openly discussing their use of some of these techniques. For example, actress Suzanne Somers talked about using acupuncture (NBC: 1/15/96), while comedian and actor Bill Cosby had an acupuncture treatment on the nationally broadcast *Live with Regis and Kathie Lee* television show (NBC: 3/7/96). Lay people, especially, are more likely to have heard of alternative health care, and associate this care with specific techniques such as acupuncture, after this type of national exposure.

There is no consensus on what techniques are alternative. However, authors commonly mention acupuncture, chiropractic, homeopathy, bodywork, biofeedback, meditation, guided imagery, Yoga and naturopathy. These techniques are becoming increasingly known, especially given the media attention just described. Yet, it is important to include lesser known
techniques such as Reiki, iridology, Bach flower remedies, polarity, autogenic training, hypnosis, neurolinguistic programming, Feldenkrais and hand analysis. Please refer to Table 3.1 for a description of these techniques.

There are a variety of ways that researchers identify a medical technique as alternative, and much of this variation depends on whether or not the researcher believes the alternative technique has merit. Opponents suggest alternative techniques are those that are not scientifically proven, lack regulation, and are often harmful to one's health and financial resources. Proponents use a different definition. The Office of Alternative Medicine, part of the National Institutes of Health, classifies alternative techniques into seven major categories: alternative systems of medical practice such as acupuncture; bioelectromagnetic applications including electroacupuncture; diet, nutrition and lifestyle changes; herbal medicine such as Ginkgo Biloba Extract; manual healing such as massage therapy; mind/body control techniques like biofeedback; and pharmacological or biological treatments including chelation therapy. Refer to Table 3.2 for a complete list of the alternative techniques they include in each category. Dr. Eisenberg and his co-authors (1993) define alternative or unconventional practices as those that are not widely available at hospitals or not widely taught at medical schools in the United States (246). Other proponents believe a technique is alternative if it adheres to a holistic ideology. I describe this ideology in the next section.

Complicating our classification of techniques as alternative is the fact that these techniques are so diverse. Alternative practitioners do not share a common professional community, language, knowledge, values, research criteria or goals as Western physicians do (Gevitz 1988:1; Wolpe 1990:913). For
example, the role of practitioners varies with each technique. Chiropractic and acupuncture require a practitioner; whereas, lay people can practice yoga and massage (Sirott & Waitzkin 1984:247).

Respondents in this study reflect the diversity of alternative techniques available. Though some practitioners told me their clients have either tried a lot of techniques or none at all, most practitioners and clients in my study have tried a wide range of alternative techniques. First, practitioners use a variety of alternative techniques from acupuncture and massage to Reiki and hand analysis with clients. As practitioners they used an average of two alternative techniques with clients. Massage, acupuncture and Traditional Chinese Medicine (TCM) are most common, though homeopathy, hand analysis and support groups are also popular. Fewer practitioners used such forms of healing as Rolfing where a therapist massages and manipulates the connective tissue to reestablish proper functioning between the muscles and bones, or Reiki where a bodyworker applies pressure to move energy throughout the body. As clients themselves, the practitioners have tried an average of five different techniques. As clients these practitioners were most likely to have tried acupuncture and chiropractic, though significant numbers had also tried homeopathy, massage, meditation and TCM. Second, the clients have tried an average of eight alternative techniques. Acupuncture, chiropractic and herbs (e.g., those used in Traditional Chinese Medicine) were the most popular techniques since well over half of the clients had tried them. Massage, healers and homeopathy were slightly less so popular.

Also complicating our definitions, these techniques can gain or lose credibility over time. For example, osteopathy has moved from a marginal, thus alternative, technique to one that has "full acceptance" by Western medicine (Wardwell 1994:1061). In Wolpe's (1990) terms they have been
absorbed (922). Similarly, some argue that orthodox or Western medicine has co-opted homeopathy (Starr 1982:107; Wardwell 1994:1065). Chiropractic medicine has moved from a marginal status to a limited medical profession that is primarily independent of, or isolated from, Western medicine (Starr 1982:108; Wardwell 1994:1061; Wolpe 1990:922). The Western medical profession has historically suppressed midwives and subjugated pharmacists (Wolpe 1990:922). Finally, researchers and lay people do not always consider acupuncture or biofeedback alternative because they have gained some credibility (Wardwell 1994:1062). Though Wolpe (1990) would argue that Western medicine has co-opted acupuncture and biofeedback, he also suggests that these techniques allow activists to test the boundaries of Western medicine much like meditation and herbs (922). In Wolpe’s model, holistic medicine experiments with certain techniques and then passes along those that are useful. Though there is disagreement over the status of each alternative technique, these authors raise an important issue. Western medicine and society’s response to alternative medicine is certainly not static. We should examine the role of alternative medicine over time. This requires understanding how society perceives these techniques individually and collectively.

Alster (1989) suggests that the techniques themselves are not the key issue, but the way practitioners use them (77). Consequently, it becomes important to understand the beliefs behind alternative health care, because they often dictate alternative health care practices (71).
ALTERNATIVE BELIEFS

A second characteristic of alternative health care is a core set of beliefs. Coulter (1979) argues that each system of medical practice has a set of assumptions about health and illness. Though Western physicians are often unaware of these assumptions since they are embedded in our culture and taken for granted, these assumptions guide physicians' practice of medicine (Coulter 1979:289). On the other hand, this core set of beliefs are at the forefront in alternative medicine. Contrary to Martin's (1990) assertion that ideology is more nebulous than values or goals, I find that holistic or alternative health care ideology is well-defined since it is so important to this movement. As Lowenberg (1989) has argued, this ideology connects diverse activists within the alternative health care movement, and constitutes the key separation between this movement and its main opponent Western medicine. My respondents easily defined alternative medicine, and readily articulated movement ideology in our discussions. In addition, most activists identified the same core beliefs.

Alternative practitioners vary as to how much they discuss the ideology behind their practice despite the importance of ideology to the movement. On one extreme are the practitioners that do not believe it is necessary to share their ideology with clients. One acupuncturist will tell clients she is open to question about the ideology behind her work. She only gives a two minute overview of "the theoretical construct that underlies [the] practice so they have confidence." She believes this short explanation helps the clients relax, because "they see a doctor is actually talking to them which does not happen in Western medicine." Yet, she says it is not vital to share this ideology, because "non-believers are healed." At the other extreme are
the practitioners that believe it is their responsibility to share the ideology even though some clients are not as receptive. A Reiki practitioner explains:

I'm reasonably certain that when I say some of these things to clients [such as] "how do you think this is affecting your overall health," that's a pretty jarring statement. That's not something they expect me to say, especially when the [Western] physician doesn't say it to them. I'm not sure what kind of an impact [it has] or even if it does, but I've done my part by making that available.

She goes on to explain that once she has developed a rapport with a client it is easier to discuss the ideology behind Reiki. Another Reiki practitioner says, "once people come to you, it's very easy to explain about that whole body-mind connection." Practitioners in the middle of these extremes assess the openness of their clients before discussing the ideology behind their work. A chiropractor would like to share more of his ideology with clients, but "unfortunately with about 50-60% of the people I see, I don't feel it's appropriate, because they will get turned off or feel uncomfortable." To assess their comfort level, this chiropractor asks "key questions." For example, he says he will know whether his clients are open to holistic ideology simply by asking if they have tried other alternative techniques.

Activists vary slightly in what they include in this ideology, yet most reiterated core beliefs defined in the literature. Kopelman and Moskop (1981) suggest that these beliefs include defining health as well-being rather than the absence of disease, stressing individual responsibility for health, advocating health education, controlling social and environmental determinants of health, and using "natural" therapeutic techniques. The respondents in this study mentioned all of these ideas except controlling social and
environmental causes of illness. They also added the importance of energy. Though the beliefs are well-defined in the literature on alternative medicine, each analytical component of the ideology comes from my data.

Some beliefs are widely adopted; whereas, others are controversial. Defining health as well-being is a reflection of the World Health Organization's definition of health (Kopelman and Moskop 1981:211). Another widely adopted belief is the connection between the mind and the body. On a personal level, many of us know that we can become sick if we experience too much stress and do not manage it properly. On a professional level, physicians are even beginning to accept this connection between the mind and the body, and conduct research to identify and measure it. Other beliefs are much more controversial. For example, alternative health care practitioners stress individual responsibility for health. On the one hand this belief is not controversial, because it simply says that as individuals we need to be educated, active participants in our own health care. On the other hand, some take this to mean that we allow ourselves to get sick. Dr. Bernie Siegel believes that clients become sick because they "need" their illness - to receive sympathy or a rest from their duties, for example. Taken to the extreme, a woman gives herself breast cancer because she was not close to her parents during childhood (Dr. Siegel 1986) or because she "visualized cancerous lumps into existence" through monthly self-breast exams (Dr. Christiane Northrup as paraphrased in Austin 1997:130). Some alternative practitioners and techniques focus, then, on changing her mindset or this psychological and emotional state (Sobel 1979:313-314). Though some take this belief literally, many more are uncomfortable with these implications. Opponents of this extreme version of individual responsibility call it victim-blaming and "lousy science" (Austin 1997:134, 136).
Though these beliefs are often controversial in the United States, importantly they are widespread throughout the world (Dubos 1979:xii). Practitioners use diverse healing practices that come from healing systems found in all parts of the world (Lowenberg 1989; Mattson 1982; Salmon 1984:238). It is also necessary to point out that these beliefs are not new. Mattson (1982) argues that it is only in Western culture within the last century that we have separated health and illness from a person's other activities, for example. I now turn separately to each belief derived from my research.

Health is Well-Being

When asked to define alternative medicine, respondents were most likely to say that health entails well-being, rather than simply the absence of disease (Goldstein et al. 1985:317; Salmon 1984:237). Seventy-nine percent (n=27) mentioned some element of this idea. Well-being suggests a certain level of balance, confidence, contentment, happiness and energy. A person could have no physical symptoms or illness, but still be considered or feel unhealthy and in need of medical care because she or he is emotionally drained, overloaded, stressed or depressed (Berliner and Salmon 1979:46).

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1 This percentage is based on 34 of the 40 respondents in my study. Four of the remaining six were asked about the ideology of integrative medicine, not alternative medicine. I was unable to hear this part of the video recording for the remaining two respondents. The remaining percentages in this chapter are based on these 34 respondents only.

2 This usage implies physical energy; however, four respondents (12%) referred to energy in another way even though most had a difficult time describing it. Whether respondents described it as "nebulous," or "intelligent," they used energy to describe a force within the body. This force has different names depending on the alternative technique. For example, Oriental doctors call it Qi. Part of health has to do with strengthening this energy. These practitioners believe our human energy field contains emotional energy created by our experiences. This emotional energy or force can affect the physical tissue of our bodies (Dr. Caroline Myss 1997:16).
This is called dis-ease (Lowenberg 1989:35). Practitioners aim for "wellness, whether you have existing disease or not." As a physician's assistant in a homeopathic clinic says, alternative medicine "look[s] at people's health as not so much what's wrong, but really how to make the most of life." As some respondents say, we should aim for holistic life, not just holistic health.

Advocates of alternative medicine argue that this belief, and subsequent clinical practice, runs counter to Western medicine's focus on eliminating illness and physical symptoms. To be well or healthy, one must have balance physically, emotionally, mentally, spiritually and socially. To help individuals attain well-being, alternative practitioners address all of these aspects of a client's life. They do not just focus on the diseased part of the client or the client's physical health (Alster 1989:64; Berliner and Salmon 1979:43; Tubesing 1979:101). One acupuncturist says that "[alternative medicine] looks at the true complexity that's going on with each individual...Let's not pretend it's just about a lesion or a bug. That's naive. People are more than that." "Healing is an effort on the system to regain its native equilibrium" between all of these dimensions. Another respondent says that "alternative [practitioners] like to consider many levels simultaneously in gearing toward a kind of homeostasis." Alternative practitioners do not separate the mind and body so they look at the role these others non-physical factors play in creating illness and disease. For example, practitioners recognize that emotions and psychological states can lead to physical disease or influence the experience of illness (Kaufman 1993:303) and that individuals with strong spiritual beliefs report fewer medical symptoms (Dr. Herbert Benson's work cited in Baker 1997:20). Practitioners treat clients
individually since each person is unique (Lowenberg 1989). They will treat two men with heart disease differently since each one has a different lifestyle, capacity for change and emotional well-being.

Spirituality is an especially large component of holistic ideology. Forty-one percent of respondents (n=14) stressed spirituality specifically in their definitions of alternative medicine, and two respondents mentioned that the alternative health care movement is moving more in this direction. One support group organizer said his clients would say they are part of a spiritual movement, because they “try to integrate spiritual principles into a physical approach.” Some clients choose practitioners based on inclusion of spiritual healing; whereas, others develop a spiritual connection through their involvement with alternative medicine. A Rolfer says that her “typical client is already deeply involved in some kind of spiritual awareness, on the receiving or the practicing end.” Some practitioners even think of their clinics primarily as spiritual centers with some alternative treatments available secondarily. Others mentioned that practitioners are often drawn to spirituality. For example, one acupuncturist says, “we don’t require that people have a spiritual orientation to be part of the group, but it turns out that everybody does in their own way. I consider that to be extremely important. In the eastern traditions the healer is the same thing as the spiritual guide or teacher.” One female practitioner even said that “if you do not address the connection between healing and the spiritual, you are just a technician.” Respondents clarify that their personal spirituality is eclectic, and the movement’s spiritual orientation is diverse. Some connect this to long-standing religious traditions such as Christianity while many others do
not. "It can be something very orthodox for one person and something just very New Age for another." An acupuncturist adds that "no one way is right."

Another component of this belief in holism is the role of emotions. Some respondents believe that emotional problems can turn into physical ailments later if the person does not resolve them or keeps them inside. One client says "you can't dissect and discount people's feelings...in their health." For these reasons, practitioners warn that "it's very important that the person be ready and accepting" since "a lot of the holistic issues deal with emotional issues and things that are going on with you. If you are not ready to work on those things then it's not going to benefit you to go to a holistic practitioner."

Individuals often require multiple therapies since alternative medicine addresses so many facets of the person, and does not believe that illness has a single etiology (Alster 1989:61). Consequently, practitioners have to communicate since each individual needs some type of coordinated care (Tubesing 1979:104). Yet, each practitioner may emphasize or work on a different level. For example, a psychic healer says, "if you can heal the energy level you can have physical healing and then mental healing. It's all one." Conversely, the director of a feminist clinic says their motto is "heal the spirit and the spirit heals the body." Likewise, one woman who organizes support groups states that they "do bring in a spiritual component. We find it to be a very essential part of the equation." An acupuncturist confirms this belief. "If a person doesn't know why they are alive, they are going to get sick. They won't be happy. Most of us [practitioners] will ask people [whether they] have a spiritual path."
Since each practitioner may only address one aspect of a client, it is questionable whether they are truly holistic in their approach. If the ideology states practitioners should look at the whole person, then only focusing on one’s physical or spiritual health is not in accordance with this. An acupuncturist acknowledges this when she says, "I do holistic health care, but I don’t bill myself as doing that because I do a very specific aspect of that, which is acupuncture and traditional Chinese medicine." Some respondents suggested that adherence to the belief in addressing the whole person separates alternative practitioners from those merely claiming to be alternative or holistic. "Many [practitioners] call themselves holistic, but they aren’t because to [take into account all aspects of their clients] is pretty unique." An acupuncturist provides an alternative viewpoint to this critique. He says alternative medicine is "not just being an acupuncturist or a homeopath. It's thinking and acting in a certain way according to these core principles." Therefore, practitioners may only be able to address one aspect of that person’s illness or well-being, but if they take into account the whole person then they will be able to refer that client to other practitioners. These referrals maintain the holistic beliefs in practice. So in order to achieve balance one might have to use numerous alternative techniques and practitioners. One chiropractor admits his work is just "one of the many pieces of the pie. In and of itself, it’s not holistic. I have to integrate other therapies or use other practitioner’s referrals to augment it."

This belief in holism affects the clients, as well. Clients will have varying degrees of interest in working on all of these dimensions, especially since in our culture we are so accustomed to focusing on physical ailments in isolation from other aspects of our lives. A dance therapist says:
Holistic health care considers that this is a whole person who doesn't just have a physical body and in my case physical complaints, but emotions that may bring up these problems or bring them to see me. They have their own ideas and thoughts about what is best for them and they may or may not be interested in the dimension beyond our physical life, which is often called spiritual.

Many authors criticize the core belief that states that health entails well-being, rather than simply the absence of disease. They argue that advocates do not clearly state the relationship between health and well-being, and what definitions exist increase the amount of illness we experience. Also, this broad emphasis puts unrealistic expectations and standards on health care professionals, especially since practitioners are not qualified to act as counselors (Alster 1989:74; Kopelman and Moskop 1981:212-213, 226).

**Individual Responsibility for Health**

The second core belief respondents mentioned (29% or n=10) is that individuals are responsible for their health. Individuals are responsible for illness, and capable of healing through self-care (Mattson 1982:45; Schwartz 1979:373). In other words, the patient has the locus of control (Sobel 1979:313-314). Consequently, success depends on an individual's socioeconomic resources, motivation and ability (Schwartz 1979:374; Sirott & Waitzkin 1984:247). One article in the *New Age Journal* helps readers become an "ideal patient". One suggestion is not to be "passive, dependent or afraid," because they assume that physicians "have all of the answers" (Adams 1997:70). This belief in individual responsibility calls into question standard treatments in
Western medicine that rely heavily on treatment, intervention and technology, rather than prevention, education and self-care (Backup and Molinaro 1984:215-6).

Individual responsibility for health is one of the key components of holistic ideology that separates alternative from Western medicine. One implication of individual responsibility for health is that individuals need to be free to choose the type of technique that is most appropriate for them. One woman explains how this affects her role as a client.

The instructor said, diet's important. The minerals are important, but your attitude is most important. This was a major turning point for me. I learned how to have a holistic attitude of life, not just health. That's how I view things now. Now when I get sick, I think where did this come from? I believe in reincarnation, and that's part of our health to, because I believe we do create what's going on with us. Now many subconscious things are going on, so our job is to become conscious. So that really changed a lot of what I did.

Certainly not everyone takes this belief as literally as this client. As I mentioned there are different ways to view this belief. Some interpret this belief to mean that individuals should do whatever they can to enable healing. Others believe we are responsible for the illnesses we experience. One client puts it this way. “If you accept responsibility for your health, you have to also accept responsibility for having gotten the disease. That can be something people don't want to do.” Focusing on individual responsibility in this way can result in blaming the victim for diseases (Berliner and Salmon 1979:43, 45; Kopelman and Moskop 1981:224). This victim blaming can lead to guilt. Lowenberg (1989) found that clients of alternative medicine felt most guilty about not making nutritional changes their practitioners recommended (196). Yet proponents argue that alternative practitioners are
compassionate, so they provide "theoretical outs" that absolve the client of self-blame and guilt (Lowenberg 1989:173, 215; Lowenberg and Davis 1994:588). For example, practitioners will empathize with how difficult it is to make significant lifestyle changes, and acknowledge that individuals get sick for reasons beyond their control. Practitioners might also recognize the role of the subconscious as a woman working with support groups illustrates.

I believe people do participate at some level, but it's not a conscious level. The choices are made out of learned experiences. It's just upsetting when people are made to feel guilty because then they say, "why am I doing this to myself? Why can't I make better choices?" It's not about that at all. There's no blame at all, because I think we all to some extent are damaged by life. So we make wrong choices for ourselves. It's important to see that we can make other choices. It's more to let people know what's possible, and not to make them feel worse about it because they can't change, or because they are afraid.

Opponents also criticize the idea that individuals are responsible for their own health, because this leads to individual solutions when social or structural ones may be necessary (Lowenberg 1989:160, 166, 227; Sirott & Waitzkin 1984:261). For example, our social class position, race, age and geographical location impact our health (Ferraro and Farmer 1996; Mirowsky 1996; Ross and Wu 1996). Focusing on individual responsibility, alternative health care can miss the importance of these larger factors and require individual, as opposed to structural, solutions. As a result, this only benefits those individuals with financial and social resources (Lowenberg 1989:227-9).

**Health Education**

Given the emphasis on individual responsibility, health education becomes critical (Tubesing 1979:104). The respondents that mentioned this belief (38% or n=13) were very emphatic that in this model, the practitioner...
becomes an educator, consultant, role model or facilitator who helps the individual mobilize his or her own healing capacities (Alster 1989:66; Lowenberg 1989:41). Proponents of alternative medicine point out that the origin of the word doctor comes from the Latin word "docere" meaning "to teach" (Haas 1992:6; Sobel 1979:6). In theory, this leads to a much more egalitarian or reciprocal relationship between practitioner and client (Goldstein et al. 1985:317-318; Lowenberg 1989:124, 230; Lowenberg and Davis 1994:579-80; Salmon 1984:240). To illustrate, some alternative practitioners have clients call them by their first name (Salmon 1984:240), use informal and non-medical language with clients (Lowenberg and Davis 1994:589), and give clients access to their medical charts (Tubesing 1979:182). Alternative practitioners often call their consumers "clients", rather than "patients" because the former implies an ongoing relationship (Alster 1989:93).

A patient is someone who goes to a practitioner and expects something to be done to them. In contrast, a client has the right to knowledge, has the power of making decisions, and is a partner in the healing process. From the very first contact, clients are helped to understand it is essential for them to participate in the healing process. This responsibility increases as they learn more skills (McGee and Chow 1995:58).

Practitioners teach the skills necessary for healing in addition to preventing the client from feeling guilty for a lack of individual responsibility for one's health. As one client stated, "instead of this [health care provider] having all the information and know[ing] what's best for you at all times, there is an exchange of information, communication and education that enables the person to heal [him/herself]." One acupuncturist explains, "you have to teach people how to be in tune with those [symptoms], and learn the right response to [them]." He suggests practitioners aren't "grand healers, but
facilitators.” Believing that we all have the capability to heal, one practitioner goes so far to say that it is hypocritical and not in line with holistic thinking to say that you are the best at a certain technique. This role can be difficult for alternative practitioners since clients do not always want to take responsibility for their health.

**The Use of Natural Remedies**

Fourth, alternative ideology believes that the body is capable of healing itself, so medical interventions simply try to speed or assist these innate capabilities. Many proponents of alternative medicine advocate natural remedies that are less intrusive and less technologically based (Goldstein et al. 1985:318; Smith 1992:154). A natural therapy would include lifestyle changes such as incorporating dietary changes, exercising, managing stress and improving one’s attitude (Haas 1992:2-3). All of these involve paying attention to the quality of your life, not just the length. It also implies that prevention and maintenance are more important in the long-run than treatment (Alster 1989:63). Over half of my respondents mentioned some element of this belief (53% or n=18). For example, one client contrasts this focus with “traditional medicine [that is] involved in care after disease is happening.” By strengthening our own healing ability, these therapies help individuals resist infection or prevent illness from developing. Since some of these “natural” alternative practices attack disease indirectly, the results often take much longer (Aakster 1986:268).

Alternative practitioners do not see illness as an enemy, but a signal that something is wrong and an opportunity for change (Alster 1989:62; Salmon 1984:242). It is important to “respect the healing process.” As opposed to Western medicine, "you don't consider it a war...You are not out
to kill anything." One client says people in his support group often say that "being HIV positive was a gift for them, [because] suddenly they got to know themselves." They were able to figure out what was really important to them. A support group organizer adds, "it helps you to drop the unessential."

In order to have true healing, alternative medicine believes you must find the cause of the problem, rather than simply "cover the symptoms." Natural remedies help clients "feel better from the inside. They are restored to a state of health you are supposed to have, which is different from a drug that's masking symptoms." As opposed to Western medicine, alternative practitioners believe that illnesses typically have multiple causes. Once you find these causes alternative medicine has clearly articulated definitions of healing and how to achieve it.

Some researchers criticize this belief in natural therapies. First, proponents argue that alternative medicine uses different definitions of the term "natural" or does not make the definition explicit (Kopelman and Moskop 1981:215, 229). Second, some Western medicines have organic components countering the claim that alternative medicine is the only type of medicine that uses natural therapies. "One quarter of all prescription drugs contain chemicals derived from plants" (Bay Area Naturally Fall 1997/Winter 1998:22). This article by Michele Klink goes on to say that prescription and herbal medicines differ philosophically. Third, many of these therapies are not realistic for most individuals. For example, in order to implement lifestyle changes, individuals need to increase their awareness, change their behaviors, and most importantly, create supportive environments that sustain better health (O'Donnell 1989:5). This is very difficult and demanding for many individuals. Finally, some critics claim that how we use these "natural" treatments are important. One homeopath says, "some confuse
holistic with natural. You can use herbs just as unholistically as drugs." For
example, if an alternative practitioner recommends herbs, but does not
address what may be causing the symptoms, then this practitioner is simply
replacing a Western drug with herbs. The treatments are different, but their
use is the same.

Social and Environmental Determinants of Health

Finally, prior theorists suggest that alternative medicine considers
social and environmental factors as major determinants of health, yet my
respondents did not mention this component (Haggerty 1979:18; McNamara
1977:5). Social factors that can cause illness include poverty and stress
(Kopelman and Moskop 1981:211). Individuals with low incomes are three
times more likely than individuals with higher incomes to have heart
disease and two times more likely to have arthritis (Weitz 1996:58). While
poverty exposes individuals to many health risks, such as lead poisoning and
malnutrition, they are less likely to have access to health care. If they are
eligible for free health care through Medicaid, many cannot find
transportation, child care or a willing provider. Those who do not qualify for
Medicaid are even less likely to have access to health care, because most
cannot afford insurance. The Kaiser Health Reform Project found that half as
many uninsured as insured individuals saw a doctor in 1993 (as quoted in
Weitz 1996:355). Donelan and her colleagues (1996) found that 45% of
uninsured individuals needed medical care, but could not receive it. In this
same study only 37% of those who were uninsured received free or
discounted medical care, contradicting "conventional wisdom that truly sick
people can always get care when they need it" (as cited in Pear 1996). Families
and social systems are also important social factors, because they can promote
or discourage health and well-being for its members (Goldstein et al. 1985:318; Mattson 1982:42; Salmon 1984:236). For example, Salmon (1984) argues that symptoms of disease and illness can be a reaction to an individual’s relationships or living environment.

Environmental factors include water and food sources. For example, poor sanitation facilities or hazardous waste sites may taint the water supply and breed illness. Some of these environmental dangers affect a limited population of people. The term “environmental racism” highlights the common practice of companies targeting specific neighborhoods, namely “communities of color,” for disposing toxic waste or locating polluting sites (Chavis 1993:3). Bullard (1983) found that since the 1920s the city of Houston placed all of its landfills and 75% of its garbage incinerators in predominantly African American neighborhoods, even though most of the city’s residents were white. Other environmental factors affect larger populations of people not restricted to a geographical area. One such threat is global warming (Lappe 1991). As chemicals such as chlorofluorocarbons (CFCs) destroy the ozone layer, more people are exposed to ultraviolet radiation, which increases the likelihood of skin cancer. Individuals are more likely to develop asthma and emphysema from their increased exposure to smog. Global warming can increase the incidence of health problems, even though scientists debate the extent of damage.

Proponents of alternative medicine may disagree as to how strong a role social and environmental factors play in health, but they agree that practitioners need to broaden their diagnostic and treatment approaches to include these elements. On one extreme, Haggerty (1979) argues that focusing our attention on social and environmental factors is more useful than emphasizing medical care, because he believes that these factors are the major
determinants of health (18). McNamara (1977) agrees that most health problems stem from environmental causes (5). Though not all alternative practitioners would agree with Haggerty or McNamara, they do believe social and environmental factors play some role in health and well-being.

CONCLUSION

Alster (1989) argues that techniques such as acupuncture are not the key element of alternative medicine, but the way practitioners and clients use these techniques in accordance with holistic beliefs (77). As an acupuncturist in my study said, alternative medicine is "not just being an acupuncturist or a homeopath. It's thinking and acting in a certain way according to these core principles." Alternative medicine does entail both a set of techniques and core beliefs; however, I have outlined each belief in detail given their importance in politicizing the movement and preventing co-optation of its techniques as I will show in the next two chapters. Holistic beliefs include defining health as well-being rather than the absence of disease, stressing individual responsibility for health, advocating health education, using "natural" therapeutic techniques, and recognizing the importance of "energy." The strength of the movement's ideology lies in the number of respondents that mentioned each of these beliefs, and the ease with which they did so.

Social movement theorists have recently re-emphasized the importance of ideology, or the widely shared, but socially constructed, beliefs, values and meanings of a movement (Hunt et al. 1994; Melucci 1995; Snow and Benford 1992; Taylor and Whittier 1995). Contemporary theorists

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3I use the word "re-emphasize" since classical social movement theorists examined the role of ideology (e.g., Smelser 1962), but early Resource Mobilization theorists neglected ideas to
discuss ideology as collective identity or framing. Collective identity is the "shared definition of a group that derives from members' common interests, experiences and solidarity" (Taylor 1989). Collective action frames are "emergent action-oriented sets of beliefs and meanings that inspire and legitimate social movement activities and campaigns" (Snow and Benford 1992:67-8). Theorists devised these new terms to illustrate that activists use these beliefs to create and sustain alternative meaning systems and collective action (Tarrow 1992). These ideas improve upon classical approaches that treated beliefs "descriptively" and "statically," and resource mobilization theory that assumed beliefs were unimportant (Snow and Benford 1992:135).

In the next two chapters I will develop my argument that alternative medicine is more than a set of techniques or beliefs. Alster (1989) argues that the alternative health care movement relies on beliefs as slogans that characterize the social movement for participants and outsiders. The beliefs, both explanatory and evocative, provide coherence to the movement (55, 70). In this way the ideology can united diverse and otherwise disconnected activists. Understanding alternative medicine as a social movement requires seeing these beliefs as part of a collective identity. The collective identity is more than these individual beliefs, but I return to ideology throughout the study because they play such a critical role within the alternative health care movement.
ACUPUNCTURE - Practitioners stimulate energy points with thin needles for varying lengths of time. Ch'i, or the life force, flows along meridians that are connected to vital organs. Stimulation of energy points along these meridians is believed to restore balance in the body. Acupressure follows the same principles, but uses the fingers to stimulate these points.

BIOFEEDBACK - Individuals are taught how to become aware of, and control, their muscle tension, heart rate, blood pressure, temperature and emotions. Monitoring electrodes connected to the body, individuals learn what affects these components of the nervous system, and through mental exercises and relaxation techniques, how to control them.

BODYWORK - A variety of techniques that attempt to improve a person's physical body and psychological state. Techniques include Yoga, massage, and Rolfing (pressure is applied to release the "knots" we feel when the connective tissue becomes thickened due to stress and inactivity).

CHIROPRACTIC - This typically involves manipulation of the spine to correct alignment since illness is believed to stem from incorrect alignments (subluxations). However, chiropractors disagree as to whether incorrect alignments can explain all illnesses, and whether force should be used to manipulate the spine to correct these. Non-force chiropractic uses only gentle techniques on muscles and joints to realign the spine, rather than force.

GUIDED IMAGERY - A mind-body technique where individuals visualize an image, and try to convince their subconscious that it is real. For example, an individual with cancer is asked to visualize the cancer cells being attacked.

HAND ANALYSIS - Studying the fingerprint and lines in our hands to facilitate all types of healing, not just physical.

HOMEOPATHY - Cure of diseases through the application of very small, diluted doses of animal, plant, and mineral substances that would produce symptoms of disease in a healthy person.

Source: Information comes from a variety of sources including clinical brochures, respondent interviews and Dr. Rosenfeld's Guide to Alternative Medicine.

Table 3.1: Definitions of Selected Alternative Techniques

(continued)
Table 3.1 (continued)

MEDITATION - Various techniques used to relax and focus the mind, and derive physical benefits from releasing stress. For example, an individual may repeat a mantra over and over again such as the word “one”.

MOVEMENT REEDUCATION - Learning how to correct bad habits that lead to illness and pain, and move in a more balanced way. For example, an individual may learn how to type at a computer without risking a repetitive stress injury such as Carpal Tunnel Syndrome.

NATUROPATHY - Treatment of illness through “natural” methods such as nutrition and exercise, rather than drugs and surgery.

NEUROLINGUISTIC PROGRAMMING - Based on the idea that our words reflect our perceptions (e.g., self-fulfilling prophecies), a therapist analyzes the words we use to talk about our health and illness, and then helps us to replace negative perceptions with positive ones through the use of psychotherapy and imaging.

REIKI - Hands-on energy transmission in order to balance the life force energy throughout the body (see acupuncture for a discussion of energy and balance).

SUPPORT GROUPS - These groups recognize that the mind and body are connected. Some groups work on emotional and spiritual healing so that physical healing may result, whereas others believe emotional and spiritual healing are goals in and of themselves, especially since physical healing is not always possible.

TRADITIONAL CHINESE MEDICINE - Includes a broad range of therapies such as acupuncture, bodywork, exercise, and herbal medicine designed to restore or maintain balance in the body. It is based on the belief that there is a life force in the body that must be in balance.
Alternative Systems of Medical Practice
   Acupuncture
   Anthroposophically Extended Medicine
   Ayurveda
   Community-Based Health Care Practices
   Environmental Medicine
   Homeopathic Medicine
   Latin American Rural Practices
   Native American Practices
   Natural Products
   Naturopathic Medicine
   Past Life Therapy
   Shamanism
   Tibetan Medicine
   Traditional Oriental Medicine

Bioelectromagnetic Applications
   Blue Light Treatment & Artificial Lighting
   Electroacupuncture
   Electromagnetic Fields
   Electrostimulation & Neuromagnetic Stimulation Devices
   Magneto resonance Spectroscopy

Diet, Nutrition, Lifestyle Changes
   Changes in Lifestyle
   Diet
   Gerson Therapy
   Macrobiotics
   Megavitamins
   Nutritional Supplements

Herbal Medicine (continued)
   Echinacea (purple coneflower)
   Ginger Rhizome
   Ginkgo Biloba Extract

Source: This list can be found on their web site (http://altmed.od.nih.gov)

Table 3.2: Categories of Alternative Techniques from The Office of Alternative Medicine, National Institutes of Health

(continued)
Table 3.2 (continued)

**Herbal Medicine (continued)**
- Ginseng Root
- Wild Chrysanthemum Flower
- Witch Hazel
- Yellowdock

**Manual Healing**
- Acupressure
- Alexander Technique
- Biofield Therapeutics
- Chiropractic Medicine
- Feldenkrais Method
- Massage Therapy
- Osteopathy
- Reflexology
- Rolfing
- Therapeutic Touch
- Trager Method
- Zone Therapy

**Mind/Body Control**
- Art Therapy
- Biofeedback
- Counseling
- Dance Therapy
- Guided Imagery
- Humor Therapy
- Hypnotherapy
- Meditation
- Music Therapy
- Prayer Therapy
- Psychotherapy
- Relaxation Techniques
- Support Groups
- Yoga

**Pharmacological & Biological Treatments**
- Anti-oxidizing Agents
- Cell Treatment
- Chelation Therapy
- Metabolic Therapy
- Oxidizing Agents (Ozone, Hydrogen Peroxide)
CHAPTER 4

COLLECTIVE IDENTITY OF ALTERNATIVE MEDICINE: CHANGING INDIVIDUALS

I think we were a decade ahead of what everyone else was doing. That was part of our problem! We were so sophisticated and so simple in what we were doing that it's difficult to be recognized by insurance, back-up doctors, hospitals [and] traditional medicine. So you have to work within that battle. It is [a battle], because in that model we are being an anarchist to the system.

Alternative medicine is more than a set of techniques or beliefs. I argue that it is more useful to conceive of alternative health care as a social movement due to the collective mentality of activists and the political action they engage in while creating a collective identity. Most studies do not describe alternative medicine as a social movement or use social movement perspectives to understand alternative medicine as a modern social phenomenon (see Schneirov and Geczik 1996 for an exception). In this chapter I use my data to describe the alternative health care movement in the San Francisco Bay area. Specifically, I outline the collective identity of activists that are changing individuals while pursuing an alternative model of medicine that challenges Western medicine as the activist’s comments above illustrate.
Some individuals deal with an illness and health care professionals privately so they never look beyond personal solutions. Others come to see medicine and society differently due to their personal experiences with illness. I am interested in this latter group, because these individuals turn their personal problems into public issues that require collective solutions aimed at the structure of medicine (Mills 1959; Taylor 1996). In order to do this, individuals need to arrive at a shared definition of their experiences with illness and medicine. New social movement theorists call this shared understanding collective identity.

Though theorists disagree whether identity politics are more critical in contemporary movements, they agree that the body has become a common site for the creation of identities (Giddens 1991; Johnston et al. 1994; Melucci 1989; Taylor 1996). Formerly private, Giddens (1991) argues that the body has become "a site of interaction, appropriation and reappropriation" (218). For this reason, the body is central to an individual's identity. This follows from new social movement theorists suggestion that the main political problems today deal with private life (Touraine 1985:779). New social movements, such as alternative health, create oppositional identities and beliefs that challenge conventional understandings of the self, body, health and illness. Activists in "new" social movements have to fight to define their lifestyle in an era of increasing state intervention, for example (Giddens 1991; Lichterman 1996).

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1Some theorists distinguish contemporary movements with a focus on identity politics from earlier movements that focused on class struggles (Cohen 1985; Kauffman 1990; Melucci 1989; Touraine 1985). Others argue that identity is critical to all social movements, past and present (Friedman and McAdam 1992; Gamson 1992; Taylor and Whittier 1992, 1995; Whittier 1995).
Ideology is a key component of collective identities. Activists in the alternative health care movement create their collective identity, in part, from the beliefs outlined in the last chapter. As we saw, each belief differentiates alternative from Western medicine which, in turn, justifies the movement's construction of an alternative medical model. Movements have an easier time mobilizing activists when they maintain a set of beliefs that sets their movement apart from the opposition, as the alternative health care movement has done (Fantasia 1988; Taylor and Whittier 1995). Dalton and Kuechler (1990) argue that new social movements mobilize activists based on shared ideological positions, rather than shared class or social positions. Activists first need to merge their beliefs with those of potential recruits, a process Snow and his co-authors (1986) call "frame alignment." Then activists need to turn beliefs into collective action or social protest.

Collective identities turn individuals into political actors (Taylor and Whittier 1992:104). Contrary to Kauffman's (1990) assertion that identity-based movements de-emphasize institutional change for "apolitical introspection," I agree with theorists who argue that the creation of an oppositional collective identity is political (Melucci 1985; Taylor 1996; Taylor and Raeburn 1995; Whittier 1995). Collective identities revolve around beliefs, practices and relationships, so they build on the holistic principles I discussed in the last chapter. Participants do not simply internalize these beliefs and learn new practices. Rather, individuals construct collective

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2 New Social Movement theorists do not necessarily disagree about the importance of ideology, but they do disagree about how to define the class base of these "new" movements or whether class is even necessary to understand these activists (Buechler 1995). Some argue that these "new" movements transcend class since they coalesce around race or gender (Klandermans and Oegema 1987). Others argue that these movements revolve around a new middle class concerned with goals, ideologies and identities more general than class alone (Cohen 1985; Offe 1985).
beliefs oriented around critique and change (Billig 1995; Klandermans 1992). Collective identities enable these participants to turn their sense of who they are into a sense of "we" tied into a movement aimed at social change (Gamson 1992). In Melucci's words (1985, 1992), activists construct "action systems." We can think of each belief as part of a road map that enables activists to criticize Western medicine, create alternative understandings, and identify ways to change our health care system. This transformation from individual to political actor takes place within "social movement communities" (Buechler 1990), "submerged networks" (Melucci 1985, 1989) and "abeyance structures" (Taylor 1989). For example, Buechler (1990) defines a social movement community as "informal networks of politicized participants who are active in promoting the goals of a social movement outside the boundaries of formal movement organizations" (61).

Activists are united through their collective identities, not shared organizational memberships, since the movement is decentralized. Clinics and activist organizations serve as localized communities that bring activists together. The movement consists of a submerged network of these social movement communities. Collective identity is the thread that various social movement communities have in common. This is similar to Taylor's (1996) argument that "ideas, discourse, identities and life changes of participants" are the site of the postpartum depression self-help movement, not organizations (19-20). Before I turn to the collective identity specifically, I show that respondents in my study believe that this submerged network of communities comprise a social movement.
COLLECTIVE MENTALITY OF ACTIVISTS

All of my respondents believe an alternative health care movement exists, and most identify as activists within it.\(^3\) Their participation in social movement communities, especially at the clinical level, is an important part of their activism. Seventy-four percent (N=23) believed unequivocally that there is a movement. The remaining twenty-six percent (N=8) were less definitive, but did not deny its existence. For example, one Reiki practitioner says, "a movement implies a conscious progression towards a goal and it's just occurring. It's not something that anybody has consciously said I'm going to go out and do this. It probably is a movement, and we're just not aware of it."

The majority of respondents in this study identify as activists within the alternative health care movement. Eighty-seven percent (N=26) of respondents define their involvement with alternative health care as activism. Of these activists, 88% (N=23) identified unequivocally; whereas, 12% (N=3) held a weaker identification. The following comments illustrate the latter group. A Reiki practitioner says "maybe I am part of a movement and I have not realized it because I certainly identify with my peers who are doing this." A massage therapist says she "feels a connection to other people." However, she is "not a big mover and shaker."

Even those respondents who said they did not identify as activists within the alternative health care movement supported it or used to be activists. Though they did not always explicitly state their reasons, I believe that one did not identify as an activist because she was newly involved with alternative medicine. Another was too busy, and yet another did not like to

\(^3\)I did not ask all respondents whether a social movement exists or whether they identify as activists, so the following percentages do not include these individuals.
follow the trends in society so she stopped her activism (not her use of alternative medicine) when the social movement became larger and more visible. The majority of respondents that did not identify as activists were clients, not practitioners (75%). One is training to be a practitioner, and said she would become involved if a governmental, financial or medical organization threatened her professional livelihood.

Much of activists' involvement with the alternative health care movement takes place in social movement communities. Lichterman (1995) defines a movement community as the "character of group bonds, the shared practices, mutual responsibility and obligation that active participants in social movement groups mostly take for granted" (515). Lichterman (1995) asserts that groups take the functions of these social movement communities for granted. In contrast to this argument, I find that respondents in my study join local communities for these benefits and leave them when they no longer provide this. Individuals join social movement communities, because they create personal and group bonds among members (Taylor 1996). One woman started with the feminist clinic, but got more involved once she saw the strong bonds among members within the spiritual center affiliated with this clinic. A director says their support groups started as a gathering of people trying to let go of fear around their illness, but developed into a community. Now the main focus of these groups is community building. Another staff member associated with these support groups describes a woman who had volunteered as a support group organizer years ago. Now that she has returned to this position, she "felt like part of her soul was suddenly being nurtured again. There's a strong feeling of that connectedness." She continues to say that these groups are "sacred," because "something magic happens, not every time and not for every person. I don't
know exactly how to describe it. It's just that everybody coming together somehow contributes something that is elevating." One Reiki practitioner explains how activists leave these communities when they no longer provide these shared bonds and sense of community. "The whole concept of how to run the [healing center] just changed. They didn't want you to visit. [These new restrictions prevented] all the spiritual things that were going on between people that made it what it was. A lot of people quit going." We need to examine how individuals develop collective identities to understand why these social movement communities are so important to activists.

**COLLECTIVE IDENTITY IN THE ALTERNATIVE HEALTH MOVEMENT**

Understanding these participants as activists requires seeing the beliefs I just outlined as part of a collective identity. Collective identity is the "shared definition of a group that derives from members' common interests, experiences and solidarity" (Taylor 1989). Taylor and Whittier (1992) argue that activists construct collective identities by creating boundaries, developing political consciousness and politicizing everyday life. Individuals become activists that identify with the alternative health care movement through these three processes. Most individuals that identify with the alternative health care movement have experience using or practicing alternative techniques. Consequently, activists create *boundaries* based on who is more likely to try alternative medicine. Many individuals turn to alternative medicine when they do not like the results or care they receive from physicians. These individuals develop *political consciousness* as they learn that others have the same frustrations and experiences with Western medicine. Their personal troubles become public issues that require collective, structural solutions (Mills 1959). Activists turn their practice and
use of alternative techniques into a form of activism that politicizes everyday life in order to improve Western medicine and support alternative beliefs. I discuss these three processes separately, but they are interrelated.

BOUNDARIES OF RACE, CLASS AND GENDER

Boundaries locate individuals as members of a group, because they establish differences between themselves and those outside the group (Taylor and Whittier 1992). In this way collective identities regulate membership and distinguish activists (Melucci 1995). These boundaries make participants aware of their similarities with other activists, as well as differences from outsiders.

We need to examine who uses and practices alternative techniques to understand whom activists include within the boundary of alternative medicine. Many individuals in the United States do not have knowledge of, or experience with, alternative medicine for a variety of reasons. This exposure is necessary for these individuals to identify with the movement. Alternative medical clinics recruit individuals into the alternative health care movement. This is similar to Ruzek’s (1978) finding that women’s clinics recruited women into the women’s movement. Consequently, I examine how individuals come to use and practice alternative medicine within these clinical settings. I find that race, class and gender form boundaries that separate activists from outsiders, because they affect whether an individual will have exposure to alternative medicine.4

4Other boundaries are possible. Schneirov and Geczik (1996) explain how activists embody their opposition to Western medicine through demanding, individual practices so I do not discuss this boundary (638). Certainly, geographical boundaries are possible too. One client said his friends in New York City were “offended that this crazy Californian would be talking about all these Californian, hippy, New Age” practices. I cannot provide information on geographical boundaries since I have limited my study to the San Francisco Bay area.
Most studies show that only those individuals who can afford to focus on quality of life issues use alternative medicine, especially women (Friedman 1985 as cited in Cable and Benson 1993:474). My study confirms these findings. Mattson (1982) conducted a study of clients at one holistic health center. Most clients were female, well educated, non-Hispanic white and middle to upper class (116). They had tried a variety of alternative techniques, but most commonly came to this clinic based on personal recommendation or hearing a practitioner speak about alternative medicine (Mattson 1982:91, 119, 146). Likewise, Tubesing (1979) examined the clientele of four church-based holistic family practices established in the 1970s. Clients were more likely to be female, married, non-Hispanic white, Protestant and middle class (191). Eighty-three percent heard about the clinic through word of mouth, and an equal number came for medical care, counseling or a combination of the two services. Lowenberg (1989) found that the middle to upper class clientele heard about alternative medicine through friends. On the other hand, working-class clientele sought out alternative practitioners only after a physician could not offer assistance. Clients from the working class faced more of a stigma for using alternative medicine than middle class individuals.

**Race and Class**

Some individuals would like to use alternative medicine, but cannot afford to use these techniques because most insurance companies will not reimburse them. One's class position is important in so far as personal ability to pay affects whether one can use alternative medicine or not. Race is important since one's class position is often tied to their race (Collins 1990; Lieberson 1980; Massey 1990; Steinberg 1981; Waters and Eschbach 1995).
certain individuals are not able to use alternative medicine because of their class position, they will be less likely to identify with the alternative health care movement.

Many individuals are restricted from using alternative medicine because insurance will not reimburse them. An acupuncturist tells me that payment is the key problem in her practice, because insurance will not cover Chinese herbs. Quite simply, "unless you have a doctor's prescription you can't get reimbursed [for alternative techniques]." One mother explains, "I take [my daughter] mainly to Western doctors, but to homeopaths too. I'd do it other way around if insurance paid [for alternative medicine]." As a massage therapist says, "I think insurance companies should pay for holistic treatments. There are valid ways of being treated, and [insurance companies] don't recognize that."

An individual's race and class position affect whether or not she or he is able to afford alternative health care since insurance does not reimburse individuals for most alternative techniques. I have found that the majority of clients are from the middle and upper class since they can afford to pay for these techniques directly. Since class position is intertwined with race in our society (Collins 1990; Lieberson 1980; Steinberg 1981), most of these clients are non-Hispanic white.\(^5\) A psychotherapist says that the typical client of alternative health care is "more middle to upper class, more white. You have to have money, because there is little insurance for it." A massage therapist

\(^5\)Mattson (1982) offers additional explanations for why people of color are less likely to use alternative medicine. She argues that if these individuals are upwardly mobile they may want to fit in, rather than engage in alternative practices that may set them apart (122). In addition, she argues that some people of color may already be familiar with some of these techniques. For example, Asian Americans may use Chinese herbs (122). This comment does not explain why they would be less likely to see a practitioner, though. Contradicting Mattson's argument further, one client says, "I have a Chinese acupuncturist and there is a sea of Asian faces since they primarily use Traditional Chinese Medicine."
explains why alternative medicine is so common in Marin county, the county north of San Francisco. She says, "Marin is a pretty elite place so [individuals have] more money available to them to try these things. [They are] not limited to their health care. A lot [of other people] don’t have money and their insurance won’t cover it." Another massage therapist adds that "insurance companies often take away [the] ability to choose; [whereas,] if you have insurance and you have money, you have a wide spectrum of choice."^6

Class position, and at times race, excludes some individuals from using alternative health care, thus identifying with the alternative health care movement. Some of my respondents said activists should be more concerned with this type of exclusion.7 Yet, I have found some exceptions to these findings on race and class. First, some individuals on government assistance are able to get specific alternative techniques reimbursed. One client said he is able to receive acupuncture treatments, because "Medi-Cal will pay for two treatments a month." Without this reimbursement, he would not be able to afford this care. It is important to point out that the reimbursement is so low that practitioners will typically only provide this service to long-standing clients. Second, the cultural diversity in the San Francisco Bay area can help explain why alternative medicine is so popular here even though those respondents in my study who used or practiced alternative medicine were racially homogeneous. This diversity leads to a

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6 Middle class individuals are also more likely to have the time necessary to educate themselves and use prevention techniques since there is no "quick-and-easy path to emotional health and physical well-being" (Domar 1996:179; Zimmerman 1987:459). The quotation, however, is from a respondent in my study.

7 Activists can potentially reach diverse audiences since media sources increasingly cover alternative medicine (Taylor 1996).
level of openness. A psychotherapist says that “in this area there are more cultures, and other cultures are so much more open to [alternative health care]. That's different from the Midwest and East.”

Individuals that cannot afford to use alternative medicine will be less likely to identify with the alternative health care movement. As I will discuss later, many individuals develop a political consciousness because they turn their personal frustration with Western medicine into a structural critique by using alternative medicine. Yet, I argue that only certain individuals can exercise this power. You need discretionary income to use these techniques. One client interested in alternative techniques sums it up by saying, “I don't have the money to do this.”

**Gender**

I have found that women are more likely to use and practice alternative medicine. Sixty percent of the clients I interviewed were women. Dr. Andrew Weil says that women are more likely than men to use alternative medicine, and buy books on the subject (Rubin 1997:117). Seventy-seven percent of the practitioners I interviewed were women, as well. Dr. Deepak Chopra finds that “women are more open, and they’re better healers” (Leland and Power 1997:54). Women, for a variety of reasons, tend to be more open to trying and practicing alternative techniques. Gender forms another boundary that separates activists from outsiders. First I discuss why women might be more likely than men to use alternative medicine as clients. Then I turn to why women are more likely to become alternative practitioners.
Many of these women turn to alternative health care as clients because Western medical institutions reflect a gender bias (Auerbach and Figert 1995; Laurence and Weinhouse 1994; Taylor 1996; Zimmerman 1987). Gender plays a role in women's and men's experiences within this institution since medicine is a product of socially constructed values, customs and roles (Zimmerman 1987). Some women feel alienated and objectified in Western medicine. For example, physicians are more likely to exclude women from clinical studies (Rosser 1994). Physicians overlook some diseases in women, such as heart disease (McKinlay 1996:1). An acupuncturist explains that "research and technology [are] controlled by men, so [there are] not as many options available to women in terms of treatments. So the structure of health care leads women to alternative health care." Another acupuncturist explains:

Where is caring? It's way out on the other end of the spectrum. So that may be a large reason why women are involved [in alternative medicine], but [this interest includes] all people who are craving to be understood, respected [and] listened to. They know something about themselves. They have something to offer. [When they] have someone come and tell them "look I'm the expert, don't tell me your diagnosis," there are more and more people that are going to go "forget it. You don't even respect me. You may have some knowledge that could be very useful to me, but forget it. I'm going to go over here."

Women may be more open to alternative medicine, because they are simply more likely than men to seek out any type of medical care (Auerbach and Figert 1995:122; Laurence and Weinhouse 1994:7; Ruzek 1978:13; U.S. Department of Health and Human Services 1991; Zimmerman 1987:446).® A

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® A publisher told Dr. Robert Ivker, author of a book on men's health, that men were not interested in their health (1997 book promotion).
clinic director says that since “women are the ones who seek health care the most anyway, they’re making the change over [to alternative medicine] quicker.” On the other hand, “men tend to wait. [They] finally get convinced to come in, [or get] dragged in.” Men would be less likely than women to seek preventive care, then, which is the crux of alternative medicine. A physician’s assistant finds that wives often persuade their husbands to try these techniques. If children are sick they take them to get health care. My respondents tell me that women often seek out alternative practitioners when physicians cannot deal effectively with their children’s ailments such as ear infections and allergies. This confirms prior research that finds women often assume responsibility for their family’s health (Auerbach and Figert 1995:122; McIntosh 1989:13).

Women may be more open to alternative health care ideology that believes medicine should address one’s physical, emotional, mental and spiritual state. Many of my respondents argue that women are more apt to agree with this belief since their reproductive cycles put them in touch with the connection between the mind and body. I asked Alice Domar, author of *Healing Mind, Healing Woman*, whether women are more open to the connection between the mind and the body. She replied, “yes, because women know that stress makes their period late” (book promotion 6/24/96). At the very least, using alternative techniques requires that one be open to the connection between emotions and the body, for example. A male client says that “people are beginning to realize that your emotions, instead of being dulled, need to be expressed, if people are going to survive with any degree of health at the end of it.” Yet, “[men] are not rewarded for communicating
about their emotions or feelings. I think it makes [men] tend to hold things in. I think that's the reason men probably have more health problems, [because they are less] able to be in touch with [their] emotional body."^9

Women live longer than men so they face more chronic illnesses (Rosser 1994). Activists and authors believe that alternative medicine is more successful with chronic illness than Western medicine (Mattson 1982:138). Dr. Eisenberg (1993) explains that "Western medicine is not very useful for some things, especially chronic diseases like certain forms of hepatitis, stomach trouble, and ulcers" (258). This may provide an additional reason why women are more likely than men to use alternative medicine.

Some consumers are weary of the lack of regulation over alternative practitioners; however, some respondents suggested that results impress women more than credentials. Some practitioners cannot get a license since the state does not regulate many alternative techniques. A hypnotherapist thinks men "are sometimes a little more impressed with education, degrees and titles than women are. Women only care if it works, and if it makes their lives better." Providing further detail, the director of a clinic explains that women do not have "that need to control [as] much [as] men. [Women are] open to things that aren't proven. Men have to have proof."

Gender also facilitates recruitment for women as practitioners. I have found that some women decide to become an alternative health care practitioner, because they believe their gender will be an advantage. As one young woman applying for naturopathic training said, "from a holistic perspective you can't dissect and discount people's feelings in...their

^Dr. Alice Domar provides one exception to this (1996). She believes that women have difficulty expressing anger due to their socialization (xviii). To prevent illness, we need to express the full range of emotions, positive and negative (159).
health...and I think that women...have the ability to access that more." This ability, if accurate, would certainly alleviate some of the complaints that clients have about Western medicine such as feeling objectified and believing physicians are emotionally distant. Of course, some men are nurturing and this would help in their work. A dance therapist says that when she gets “into issues of recovery from childhood abuse, which is often linked to chronic pain, certainly a nurturing female is a strong asset but I'm not sure if it's better than being a nurturing man.”

Other female practitioners cited practical reasons for choosing alternative medicine as a career. Women choose these professions for the flexibility of schedule since it allows them to balance work and family. I asked an acupuncturist if this was due to the ideology behind alternative medicine. In other words, are women able to balance work and family since this is a more holistic view of life? She said that it is simply difficult to see many patients in one week so this narrows the time one needs to be available. Practically speaking, much of the training for these specialties is less time consuming and less expensive than medical school. Training in Reiki, for example, entails a two day program for $125 to enroll in a first degree class, or an additional two day program and $250 for the second degree class.

Women may be better able to assume the financial risk associated with alternative practices since one needs to build a client base of people that can afford this type of care. Many respondents suggested that women can be more “adventurous” in their career decisions, as one chiropractor puts it. They can pursue something that interests them rather than out of financial obligations. A homeopath says that women "are less motivated by money - and many can afford to be because they have [a] husband that's working a good job. They don't have to worry about supporting a family. Many women in our
program have financial freedom." A brochure advertising a local graduate program in holistic studies said "align your career with the vision of your heart." Choosing a profession based on interest rather than financial considerations can be a drawback, though. One acupuncturist said that the practitioners who trained her had large, successful practices, but she has struggled to find the same financial stability. She says she should have considered financial stability when choosing her career rather than simply personal interest.

Other women pursue a career in alternative medicine because of the various histories of these techniques. Historically, alternative medicine has been much more open to female practitioners than Western medicine.10 "Women have always played a significant role in the genesis and growth of unorthodox medicine" (Gevitz 1988:viii). To illustrate, Mary Gove Nichols and Thomas Low Nichols established the American Hydropathic Institute in 1851. Of the first twenty students, nine were women (Blake 1984:366). The field of hydropathy allowed women to train as physicians, normalized female physiology, valued women’s roles as caretakers, and established a nurturing community among female practitioners (Cayleff 1988:83, 85-87, 92-3). Similarly, by 1880 nine of eleven homeopathic schools allowed women to train as practitioners (Barlow and Powell 1984:422). Many of these female

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10Seventeen medical schools for women were established in the second part of the nineteenth century. After a long battle, medical schools finally admitted women in 1890 after they essentially bought their way in (Starr 1982:117). Yet, "deliberate policies of discrimination" soon forced women away from medical school (Starr 1982:124). For example, the Flexner report published in 1910 led to increased standards in medical schools (Weitz 1996:229). Positions in medical schools grew scarce as many medical schools closed their doors. "Schools that previously had liberal policies toward women increasingly excluded them" (Starr 1982:124).
homeopaths formed professional associations, such as The Woman's Homeopathic Medical Association of Chicago established in 1879 (Marrett 1984:433).

**Participating but not Identifying**

Some individuals do not identify with the movement despite using or practicing alternative techniques. For example, activists suggested that some physicians do not identify with the movement because of the threat to their professional reputation. We can infer barriers that prevent identification with the alternative health care movement from prior research on who is more likely to participate in a social movement. These barriers include isolation from other activists (McAdam 1986; Snow et al. 1980) and concrete barriers such as conflicting social responsibilities (Klandermans and Oegema 1987; McCarthy and Zald 1973). One respondent in this study mentioned that she did not have time to participate in the movement.

Individuals find it difficult to turn their use or practice of alternative medicine into a collective identity and/or activism for numerous reasons. Activists identify these barriers by talking to others since the majority of respondents identify as activists. First, the diversity among alternative medicine makes it difficult for activists to identify with one another. Many individuals focus exclusively on one alternative technique, and they do not readily identify with individuals that use or practice other techniques. An acupuncturist says, “it’s not like holistic practitioners stick together.” Second, some respondents suggested that alternative practitioners are more likely to identify with the alternative health care movement than clients. A Reiki practitioner says that the clients she sees “just need help. It may not be activism [for them].” It is important to keep in mind that three out of the
four respondents who did not identify as activists in this study were clients. Third, some of these techniques require abilities that can overwhelm a person. One Reiki practitioner said upon learning that she had psychic abilities that she eventually used in her nursing practice, "it's a constant adjustment that this is really happening. That's overwhelming, especially at the beginning. There probably is [a social movement] and I'm not aware of it, because I was just so blown away by this happening to me." Though later in the interview she said she did identify as an activist, her experience points out that some individuals may need time to adjust to their new abilities before they are free to turn to identification and activism. Fourth, some individuals do not feel connected to a movement because of the threat to their professional reputation. This is especially true for physicians. Many physicians do not even tell their spouse they are using alternative medicine, so they are certainly not always going to be willing to identify with movement and be visibly active within it. Fifth, the level of success the alternative health care movement has achieved can also hamper further recruitment efforts, because many believe activism is no longer necessary.11 A woman studying Qigong says she is not active in the movement.

I think probably twenty years ago it would have been difficult to tell anybody that I'm practicing alternative health care. Now I think more and more people are expecting that this is out there, and it's widely used, and it's not weird. So I don't feel [there is] a movement.

Finally, there are no large, visible social movement organizations that potential activists could contact. For example, there are no national

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11Researchers make a similar argument about why women refuse to identify as feminists and join women's movements (e.g., Keene 1991 and Renzetti 1987).
organizations that represent the movement. Without this it is harder for potential activists to find a place to meet other "like-minded people," and turn their involvement into identification with the movement.

These barriers remind us that individuals may use or practice alternative medicine without identifying with the movement. Consequently, it is important to examine how participants develop a political consciousness, which is the second component of a collective identity.

POLITICAL CONSCIOUSNESS

Social movements need to enable individuals to blame their grievances on a structural rather than personal cause in order to develop an oppositional consciousness (Ferree and Miller 1985). Consciousness involves "interpretive frameworks that emerge out of a challenging group's struggle to define and realize its interests" (Taylor and Whittier 1992:114). Individuals make their boundaries political since they define their interests in opposition to dominant groups. Activists do more than introduce participants to specific ways of believing and acting. They are encouraging participants to develop a political consciousness by enabling them to blame the structure of Western medicine for their discontent.

Using and practicing alternative medicine gives participants a new interpretation of health, illness and Western medicine. Individuals begin to attribute their grievances to a structural cause, namely the structure of Western medicine. These individuals learn not only to change themselves, but to change the system. Activists develop a common bond through their shared negative experiences with Western medicine. For example, many women develop a feminist critique. They begin to share a common language, such as their references to a health care "industry." I show how activists
criticize the structure of Western medicine, and then develop an alternative understanding. These two elements form the basis of their political consciousness.

**Developing a Structural Critique of Western Medicine**

Individuals begin to evaluate and critique Western medicine as they interact with activists in social movement communities. Their critique revolves around Western tools such as drugs and the way physicians practice Western medicine. Activists are particularly frustrated with the lack of results and type of care they receive under physicians. Once they see how different alternative medicine is they begin to see that medicine does not have to be alienating, impersonal and disempowering. These individuals develop a political consciousness as they attribute their problems with physicians to the structure of Western medicine, not their individual relationships with Western providers. To illustrate this leap from a personal to structural critique, I show how women develop a feminist framework blaming the structure of Western medicine for their negative experiences.

Personal experience with illness, along with dissatisfaction with Western results or care, is one of the leading reasons why individuals turn to alternative medicine. Furnham and Smith (1988) found that individuals who turn to homeopathy were more critical of, and disenchanted with,

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12 Even consumers that are satisfied with their relationship with a physician can develop a structural critique. Dr. Anderson (1993) sees many patients who “may like their individual doctors, but don’t like organized medicine” (33). Likewise, Starr (1982) points out that individual consumers may be satisfied with their physicians, but we are not confident about physicians as a group. For example, consumers are questioning whether Western medical care has made any difference in their overall health (Starr 1982:408). Many turn to alternative medicine and develop a structural critique of Western medicine since they are dissatisfied with Western medicine.
Western medicine (689). Even though holistic ideology stresses alternative techniques for prevention, most clients wait to see a medical practitioner until they have a medical condition that they can no longer ignore. This follows the finding that most clients visit an alternative practitioner for a specific problem. For example, three-quarters of respondents in Lowenberg's study (1989) were seeking medical care for a chronic illness (96-134). A Reiki practitioner says, "some of the people will come to you [for] preventative [reasons], but most of them already have tremendous problems and have tried a variety of things." This is true of health care, in general. As one client explains, "I think until you're in a place where you are in physical pain, or you are scared, there's no real reason to move on something until you see a real need." This finding is ironic given that many say they prefer alternative medicine over Western medicine because of this focus on prevention.

Many individuals first try Western medicine, but turn to alternative medicine when they become frustrated with the results. For example, a Reiki practitioner says, "I had never explored hypnosis until everything failed and I tried it. I had [tried] traditional medicine and I was very discouraged. I thought there has to be a better way to do this." In addition, many clients of alternative medicine have chronic problems, as opposed to acute conditions. Respondents believe alternative medicine is better for these chronic ailments such as arthritis, because they can improve their quality of life; whereas, Western medicine does not have much to offer. A respondent studying Qigong says:

My own doctor says the hardest thing as a [Western medical] doctor is to have this revolving door [for] a number of patients [where all she] can do is give painkillers or some kind of maintenance drug. For example, people with backaches are constantly with doctors and very often they can do very little about it,
or they can help the patient get over this bout of back pain and it’s back in six months again. Many of the alternatives help people to deal with that and get rid of that on a permanent basis.

Clients are particularly frustrated that physicians continually give Western drugs that do not cure their illnesses. A nurse says physicians overuse prescription drugs because they “have lost touch with any other way to cure people. I don't think they know how to do anything but write prescriptions. I think it's pretty sad.” Given the climate of the Bay area, this happens a great deal with parents who tire of repeatedly giving their children antibiotics for ear infections without seeing results. A homeopath says “they've seen their child be given the fifth course of antibiotics, and they still have an earache.” One practitioner has even seen the largest growth in her practice from these parents seeking alternatives to Western drugs.

Physicians also tell numerous clients that Western medicine has nothing else to offer, so individuals become frustrated when they do not see results. A woman studying Qigong suggests that “most of the ones who have conditions like cancer are the ones [where the] Western medicine profession says we can't do anything else.” Unwilling to give up, they turn to alternative practitioners. A clinic director explains that “there are the truly desperate people. They've done everything. They are very sick. They don't have options so they figure I don't care if it's the voodoo man, I'm going to try something.” As a chiropractor puts it, “some are fearful. They don’t know quite what to expect. They could be [thinking] I don’t think it’s going to work, but I'll try it because what have I got to lose.”

Activists see that Western medicine as a whole, not just their individual physician, has problems curing many illnesses and overusing drugs. In many cases, activists gain this perspective from working with
numerous physicians or clients who have seen multiple physicians. The nurse believes physicians overuse drugs because she has worked with several physicians in Western settings. A physician’s assistant said he grew frustrated with the lack of results in Western medicine since he "worked in hospitals and labs specifically, and he didn’t see people getting better. I kept seeing the same people coming back over and over again." A respondent working in women’s health care says:

In a lot of menopausal women, they say, I'm 43 years old and I'm having peri-menopausal symptoms or menopausal symptoms and I went to my [Western medical] doctor and he said that was impossible. You can start that when you are 35. Because of the nature of my work [in women's health care], I'm regularly told horror stories. The part that bothers me a little bit is that the woman doesn't know it is a horror story. She knows it isn't good, but she doesn't know how bad it is.

In other cases, individuals develop a critique of Western medicine when they learn that others have the same experiences. Members share information and stories within social movement communities. One woman who organizes support groups says:

There are people who come to the [support] groups who are very cynical about the whole medical profession. They've been put through the ringer some of them. It's just a ghastly experience. Sometimes it's been a year and finally the diagnosis is made and if they'd gotten it a year ago they would have been so much better off. So they come bruised, beaten down, very discouraged and very angry. They come here for healing. That's what we are all looking for.”

Members develop a political consciousness through exchanging stories and finding that they are not the only ones with this type of negative experience. This organizer goes on to say that people learn through these groups that “we
are all in the same boat.” To illustrate, each week group members tell the others how they are feeling, and what is going on with their medical condition. Other members then get to “respond to one another because most of the people understand what the person’s talking about. [They] have experienced something very similar or exactly the same thing. We do not give advice. [Instead] they are sharing [to] affirm one another.”

These stories also provide members with an alternative approach to health care. Dr. Rachel Naomi Remen believes that wisdom gets passed along through stories. “A good story is like a compass on a long journey. It gives you direction” (book promotion on 10/8/96). They help individuals who are sick “find someone who has lived another way.” Healthy individuals can turn back to these stories to reveal their meaning once sick. As we stop telling the stories, Dr. Remen believes we increasingly need self-help books and expert advice. The feminist clinic shares these stories through their newsletter while the interest group used the health fair to pass on information. One female respondent says clients in their support groups learn how to heal themselves. Leaders teach group members how to support that healing process and help others do the same, rather than teach them a new substantive approach to healing. The feminist clinic has also created support groups for new mothers so that they can share information and provide support. Individual practitioners also “incorporate several alternative ways of looking at a problem.” This Reiki therapist continues to say that “holistic health care...lets you look at other possibilities.”

The inadequate care physicians provide, given their medical training, frustrates some clients more than the results. Western medical schools often stress detachment, or the impression that the medical doctor is personally disinterested; whereas, prior research has suggested that alternative
practitioners are sympathetic and emotionally involved with their clients (Easthope 1985:53, 56–7). Jaffe (1986) suggests that medical trainers assume that detachment helps a physician survive in a stressful job, but being emotionally involved actually helps with the emotional demands of a medical job (Jaffe 1986:204; Lowenberg 1989:12, 138). For example, Dr. Rachel Naomi Remen says that physicians feel drained from their work, because they do not know how to receive anything back from their clients (book promotion on 10/8/96). One female client in my study explains that physicians do not develop personal relationships with patients. She attributes this problem to the structure of Western medicine, or physician’s training, not individual patients. She says that “a lot of physicians don’t receive training in what is traditionally called bedside manner. They’re not trained to empathize with the person.” Rather, “they’re trained to look at this person to figure out what’s wrong with them, and give them something to make them better.”

Given these personal experiences and structural critique, many of these individuals have come to a point where they question the advice of a physician. One client says:

> a number of people I know have been disappointed when doctors try to convince them about diet, and they realize that they have one day [of training]. It’s totally ridiculous. They start seeing that there are areas where the physician really doesn't have the best information, and that encourages them to use a physician for what they can and to explore [alternatives].

Another client says that more people are beginning to think “maybe these Gods on a pedestal really are not all perfect.” A massage therapist adds that individuals are beginning to learn that “they have the power to change things. It’s not the doctor with the power.”
Developing an Alternative Understanding

Creating a political consciousness requires that activists develop more than a personal, or even structural, critique of Western medicine. It also includes identifying with alternative beliefs and practices so that individuals can compare the structure of alternative medicine to Western medicine. Activists may have tried alternative medicine in response to their frustrations with Western medicine, but they stay with these practices because the techniques work and the beliefs resonate. Most importantly, these experiences have a transformative effect because participants turn their use or practice of alternative medicine into identification with the movement.

Alternative practitioners were the first to offer many individuals hope and solutions to their medical condition. For example, a Reiki practitioner tried alternative medicine, "because most of my life I had been very overweight, very depressed - a lot of issues going on that I hadn't been able to solve. I had physical problems. I got into it and found out that there were ways that I could change those things." She went on to say, "I think people are becoming more used to thinking...well, [if] the doctors aren't figuring out what's wrong here then I have other alternatives to explore."

Individuals only stay with an alternative technique if it is either working or if the care is better. "If people weren't getting results, they wouldn't continue," explains a male client. Often times, this means individuals need to try several techniques. Another male client explains that "it's also my frustration not feeling any different. I tried a lot of Western and Chinese herbs, and nothing was working. Then one day I came across a book and just started doing [the Qigong] exercises right then. [I] started immediately saying 'I feel good.'" Alternative medicine helps clients in many ways such as increasing energy to reducing stress. A male client tried
acupuncture because he wanted to quit smoking. He found that acupuncture also helped him with stress reduction. After an acupuncture treatment, "I would just go to sleep or when it was over, I felt like I had been tuned up. It was wonderful." Several clients said they gained mobility after accidents through alternative medicine. Finally, some clients no longer get illnesses of any kind, or they are able to treat illnesses without Western drugs.

Positive experiences with alternative medicine have a transformative effect. Individuals readily identify with alternative medicine given these dramatic results and vivid contrast with Western medicine. A massage therapist "saw how it changed my health and everything [else in my life]." A client says she is active in the movement, because alternative medicine has "changed my life." A hypnotherapist said that one of the other practitioners she works with had back pain that Western medicine could not help. Within a week of various alternative therapies "he was up and about. When that happens it does make a really profound difference in your life. You see that there's something else out there."

Many individuals in my study decided to become an alternative practitioner due to these personal experiences with Western and alternative medicine. For example, one woman is applying to naturopathic schools because she "had a really horrible experience with Western medicine...As a naturopathic physician you are trained like a general practitioner. So you can help people like myself who [need a variety of techniques to get better after an injury or illness]." One person became a chiropractor because this technique alleviated his own back problems. One participant said that "99.9%" of students are enrolled in a Qigong training program due to personal health reasons.
Other individuals start to identify with the alternative health care movement, because they begin to agree with the holistic beliefs I discussed in the last chapter (Dalton and Kuechler 1990; Fantasia 1988; Taylor and Whittier 1995). For example, clients believe their mental state affects their physical health. One client explains that he is "very aware. If I get angry and let myself explode, I will break out in herpes within 30 minutes to an hour and a half." Clients want a medical practitioner that will explore this mind-body connection and offer treatments that address both. Another client explains that the:

key difference [between Western and alternative medicine] is the idea of the whole approach. I'm not saying there aren't good MD's out there that won't look at [the] whole body. Traditional medicine [is] involved in care after disease is happening, and not preventative [medicine].

In particular, many individuals come to identify with the holistic principle that they are personally responsible for their health. Alternative practitioners offer clients more involvement in their health care. One client says, "I think part of it is just observing, and then becoming curious enough or taking some responsibility and realizing that thoughts, etc. are creating our picture of health, our attitudes [and] our reality." Another client says she "self-monitored [my Grave's disease]. I guess most people think it's risky, but I think I can monitor my body." An acupuncturist says she "thinks holistic health care is more personal. Rather than presenting yourself to the doctor and saying fix me, I'm broken, they can do something about it." When they see results they know "they have a part in that."
Clients refer to the feminist women’s center as “an oasis for self healing.” The practitioner’s role is to educate and “guide” clients in developing their “self-healing life-force energies” (flyer). The director remembers coming to this women’s clinic as a client when it first opened. She had a chronic condition that physicians kept telling her was a “medical problem.” When she told the Nurse Practitioner that she thought it was not a problem, but her normal physical condition, the Nurse Practitioner agreed. She recalls how powerful it was to have a physician tell her she was correct about her own body. After that, she never had a physical problem with the condition again. She does not believe that her body changed. Rather, this experience with the Nurse Practitioner changed her knowledge and confidence. One client agrees with the director that this clinic is different because the practitioners listen and believe clients know their own bodies. She says that there is more communication with the practitioners at this clinic. She feels they really listen to her, and "respect me for being an intelligent person who knows my body."

**Developing a Feminist Critique**

In the last chapter I mentioned that opponents criticize the idea that individuals are responsible for their own health, because this leads to individual solutions when social or structural ones may be necessary (Lowenberg 1989:160, 166, 227; Sirott & Waitzkin 1984:261). Yet, activists recognize that one’s class, race, age and gender impact our health. Gender provides a good example of how individuals begin to see their problems with Western medicine as structural, not personal.13

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13Activists develop political consciousness around other issues that relate to alternative medicine besides gender. For example, a homeopath says that “humans are looking at the
Women often develop or maintain a feminist consciousness through their involvement with alternative medicine (Lowenberg 1989; Miles 1984). A male client says that “women realize very early on that Western medicine has very little for them.” Respondents mentioned a variety of ways that this happens. For example, physicians are more likely to attribute women’s than men’s physical complaints to emotional problems rather than physical illness (Bernstein and Kane 1981; Zola 1991). Several respondents mentioned that physicians have told women that a symptom or illness is “all in their head.” One client says that “men don’t understand how a woman’s body works, only by observation. Since a physician doesn’t like not knowing, he’ll say it doesn’t exist.” Some said that this problem worsens as women age since women experience more health problems, thus they have more contact with physicians who may treat them in this condescending way. These women turn their personal frustrations with physicians into a structural, feminist critique of Western medicine through their interactions with other activists. One practitioner discusses feminism with her clients, for example. In their clinic’s newsletter she asked clients to “take a moment to look at your standards for judging yourself. Do you have a male ideology of what a female body should look like?” Another one of their brochures says that they “focus on women’s issues as well as validating your female creative energy.”

From these interactions activists attribute their personal problems with Western medicine to their gender, and become empowered to make changes. A rolfer says she realized that Western medicine revolved “around the needs of males.” A therapist believes "that women aren't as affirmed in the Western tradition." A client says she “definitely felt like a woman as I was world in more holistic ways. Ecology of the planet looks at the whole system and that relates directly to holistic medicine.”

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sitting in his office and he was telling me that he thought I was depressed. I definitely felt like a part of his diagnosis was based on my gender.” When an authority figure says this it “makes you doubt yourself so much more. The more you doubt yourself, the more you become depressed, because your own foundation for believing in yourself falters.” In contrast, alternative practitioners empower women to take an active role in their health care. A homeopath explains that the collective identity of alternative medicine and feminism are “about women taking power and control over their lives,” and “finding their voices.” Some women formed empowering relationships with alternative practitioners, and learned how to “stand up” to physicians. One practitioner helps female cancer patients resist physician’s attempts to rush them into a decision regarding treatment, for example. A female client says that “a lot of women are coming forward and demanding better service,” especially since they are spending their own money on these services.

There are some caveats about gender. First, one homeopath says that “there are gender biases in alternative medicine, as well. It happens much less than in allopathic medicine, but it is still there. No matter what your training, you can’t escape gender.” Second, one client feels that the practitioners within the feminist women’s clinic really listen to her, and "respect me for being an intelligent person who knows my body." She contrasts this with physicians who “laugh her off and act as if she doesn’t know her body.” She used to think physicians treated her this way due to her gender. Now she thinks it is their training and the structure of Western medicine. Whether activists recognize a gender bias in Western medicine or not, they develop a political consciousness as they attribute their problems with physicians to the structure of Western medicine rather than their personal failings.
Activists' language is illustrative of this shift toward a political consciousness. Their comments reflect a critique of Western medicine, not simply individual physicians. Several respondents point to structural changes affecting Western medicine, such as the shift to financial motives under managed care. For example, activists referred to a health care industry. One client says that "primary care physicians want the doctor to see [the client], because they don't want to refer the patient out. They want all the money." She contrasts this with alternative medicine where "it's more about developing a relationship, getting to know the person and how they respond to different therapies." As she explains later, finances drive one system and philosophy the other. This illustrates that the beliefs are the key differentiation between the movement and Western medicine. They comprise a key part of activists' oppositional identity. With alternative medicine clients know "they haven't been a passive receptor of this giant health care thing," says another woman.

Whether activists refer to a health care industry or criticize Western medicine overall, these examples illustrate the leap individuals make to a structural focus. Activists turn self-definitions into collective identity through this political consciousness. This consciousness leads participants to feel a sense of injustice that justifies collective action (Melucci 1995). We need to examine personalized political strategies, then, to see how activists act on their political consciousness. These strategies are the third component of a collective identity.
POLITICIZING EVERYDAY LIFE

Scholars note that many social movements have employed what Lichterman (1995) calls personalized political strategies (Echols 1989; Epstein 1988; Taylor 1996; Taylor and Rupp 1993; Taylor and Whittier 1992; Whittier 1995). Lichterman argues that activists engage in personalized political strategies in their everyday life, not through their participation in social movement organizations. Taylor and Raeburn (1995) show how these personalized strategies or identity politics are a form of high-risk activism with political consequences. Members of the Sociologists' Lesbian and Gay Caucus engage in personalized political resistance by researching, teaching and discussing lesbian, gay and bisexual topics. These tactics create collective consciousness and generate collective resistance even though they are the political expressions of individuals, not necessarily organizations.

Practitioners and clients engage in different types of personalized political strategies. I show how clients engage in personalized political strategies when they choose alternative medicine as consumers. In contrast, practitioners deliver services, empower people and transform the workplace (Hoffman 1989). In addition to the strategies Hoffman identifies in her study of professional activists within medicine, I add educating the public. Even though it is another way to empower individuals, this strategy takes place outside health care clinics.

Choosing Alternative Medicine

Clients believe that using alternative medicine is a form of activism, because their choices have political consequences since they are influencing physicians, friends and family. An assistant in a homeopathic clinic says she "participated in the movement as someone who was seeking holistic health
care and now as a practitioner.” One client says she is active in the movement “in so far as I boycott Western medicine as much as I can.” Another client says she discontinued her health insurance coverage, and spends that amount on alternative techniques ranging from massage to intravenous hydrogen peroxide treatments. Investing money in alternative medicine instead of Western medicine is a deliberate tactic to raise awareness. Later I will show that physicians are getting the message.

Practitioners gain clients when activists spread the word about the effectiveness of alternative medicine, and this sends another message to Western medicine. One client says that part of his activism is “letting people know what has worked for me. I'd be happy to give them my acupuncturist's phone number. [I try to] get people to move on things.” He adds that “everybody who knows me is much more open about acupuncture because of my experiences. A number of people have tried it because of that.” An acupuncturist said she often recommends alternative health care techniques to her friends, rather than Western medicine. This type of recommendation occurs more frequently among certain groups. For example, one client says, “I think in the AIDS community, specifically, there has been a great emphasis on finding out what works from other people.” Though alternative practitioners obtain clients through referrals from a variety of medical practitioners, both alternative and Western, most practitioners rely on “word of mouth” for clients. A chiropractor says that this method is superior to all

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14Another practitioner qualifies this statement by saying that gay men have developed a subculture and network to respond to the AIDS epidemic; whereas, women with AIDS have not created these networks so they "they fall through the cracks."
others "by far." One acupuncturist says she does very little advertising. Her office manager explains that "when it works they want their loved one to have the same experience."

Using alternative medicine and sharing one’s experiences are both personalized political strategies. Activists empower themselves and others in order to make social changes. A volunteer at an alternative clinic says:

I think change starts from within yourself, so that’s what I’m focusing on right now. Then [I will] empower individuals. I think working with individuals, the word will spread, not just words, but feelings and thoughts. So they’re more empowered because of their health. Whether it be political change or social change, they’ll be able to be more focused and more sensitive.

He goes on to say that "protesting and boycotting [are] all good, but I just know there’s other ways of having your voice heard, and other ways of making change than [the] traditional marching in. Those [methods] are good. There are just other ways." A homeopath adds, "I think the world will change more when people change rather than holding a sign. That’s holistic too—to have the whole person involved, not just what they say or do."

Delivering Services, Empowering People and Transforming the Workplace

The relationships practitioners develop with their clients are deliberate strategies that address patient’s concerns with Western medicine and provide an alternative model of medicine. These relationships are the critical variable differentiating alternative health care from allopathic medicine (Lowenberg 1989), and form the basis of the personalized political strategies that practitioners use. By examining these practitioner-client relationships, I have found that the alternative health care movement uses a variety of strategies that social movement theorists traditionally have not recognized.
The strategies of delivering services, empowering people and transforming the workplace are connected so I discuss them together.

Many alternative practitioners create offices that are different from, and improve upon, Western medical offices. They organize their clinics in noticeably different ways. Many alternative practitioners make their offices as comfortable and relaxing for the client as possible. I observed a solo practitioner that shares office space with other alternative practitioners. When I asked how her clinic was different from a Western medical office, this acupuncturist says, "I make it as different as possible! I have nice rooms with music playing. I make it look nice for them. Coming to my office is like coming to my home. They are like guests of mine." The feminist women's clinic also distinguishes itself from Western clinics through subtle differences such as the decorations. Staff try to create a warm, relaxing atmosphere by using fresh flowers, plants, and personal artwork such as photographs of mothers and children who used their birthing services. They provide clients with snacks and herbal tea. The nurse practitioner does not have her medical diploma on the examining room wall.

These practitioners transform the workplace into an arena for empowering individuals. Some alternative health care practitioners aim for more egalitarian relationships with their clients following the belief that practitioners should act as facilitators and educators. For example, staff within the feminist women's clinic have clients call them by their first names, and include them in decisions about what course of treatment to pursue. Practitioners include clients in medical decisions based on the core belief that individuals must take responsibility for their health (Kopelman and Moskop 1981). The director of the feminist clinic says that "instead of this person [physician] having all the information and know[ing] what's best for
you at all times...there is an exchange of information, communication and education that enables the person to heal [him or herself]." Though few seek alternative medicine for empowerment solely, many respondents still discussed what an advantage this is for them. This is contrary to Taylor's (1979) assertion that many clients want "real" doctors, not ones without white coats that asked clients to call them by their first names (42). I believe that my respondents liked this aspect because of the benefits that come with this responsibility. In contrast to the feelings of alienation some patients feel in Western medicine, clients often feel more control and involvement with alternative health care, because they are not "passive receptors of this giant health care [industry]." A massage therapist says that clients see "they have the power to change things. It's not the doctor with the power." One female client says, "there's a lot less top down in holistic medicine. It tends to be more personal. You can feel their caring more. It's not so distant, and you are not objectified."

In contrast to Western physicians, alternative health care practitioners try to address the whole person, not just their condition or symptoms. This is a key component of holistic ideology, and the belief mentioned most often by respondents. One client says that alternative medicine is about "seeing the whole person, [and] seeing what's best for that person." A hypnotherapist says that "it is more of an emotional involvement in holistic health care than regular medicine," because alternative practitioners typically ask about the client's emotional and mental well-being, as well as physical health. "Holistic health care is more personal," she continues. This is different from the objectification some patients feel in Western medicine, especially since
physicians often send patients to specialists who treat only one body part or illness. This also contrasts with patients' perceptions of physicians as emotionally distant and impersonal (TIME 1996:43).

Alternative practitioners spend more time with clients, both to address the person holistically and to provide better care than physicians. Consumers can feel rushed with Western physicians since they feel as if they are "pushing as many people as possible through." In contrast, one acupuncturist says she will "sit and chat with them. I know all my clients very personally. I don't rush them...I'm available to talk during the week." One client simply says, "you spend more time with holistic [practitioners] generally." Over one-fourth of my respondents agreed. Along with spending time is the belief that alternative practitioners are more likely to listen to clients. A homeopath explains that "the clients expect to be heard - and it's not questions, but listening and understanding. It would have saved a lot of trouble if this would have happened earlier."

The listening skills of alternative practitioners are evident in the feminist women's clinic. Practitioners try to "take the clock out of" their work. The director explains that "if during your pre-natal [exam you explain that you had] a really bad fight with your partner and now you're questioning the safety of your home for your child, well maybe we need a little longer appointment today." My observations confirm this statement. During a three hour clinic one afternoon the Nurse Practitioner only saw three patients, because "we don't try to overbook our day." The director believes that this differentiates their organization from a medical clinic or doctor's office. In addition, she says that their listening skills are key. For example, the director will talk with women after they finish their physical exams. She
says she does not have an agenda, but just listens.\textsuperscript{15} She believes that it is very powerful for these women to have someone listen, especially since the physical exam can be traumatic for victims of sexual abuse.

As Western physicians become increasingly reliant on technology, "the traditional personal bond between doctor and patient" gets strained. Managed care further attenuates this relationship (\textit{TIME} 1996:11, 13). These personalized political strategies are an attempt by practitioners to counter this strain by developing a different type of relationship with clients. Yet, the strategy of client empowerment also helps the movement gain participants, exposure and successes. Developing a collective identity among individual activists enables collective action and institutional change.

\textbf{Educating the Public}

The movement is trying to educate the public in a more comprehensive way about alternative medicine beyond personal forms of outreach such as talking to one's friends. The movement has used public lectures and health fairs to educate and empower larger audiences about specific techniques or alternative medicine more generally.\textsuperscript{16} For example, one respondent suggested that chiropractors need to educate the public about their profession. More generally, some respondents said it is important to spread the word and talk about the effectiveness of all alternative treatments.

\textsuperscript{15}The director of the feminist women's clinic offers to listen to all clients, but there are some women who do not want this service. For these women, "there are no issues. They just come in, have their body examined, and then go."

\textsuperscript{16}See Taylor (1996) for a discussion of these strategies within the postpartum depression self-help movement, especially the role of talk shows and other forms of media that enable activists to reach large audiences.
One common tactic used to educate and empower the public outside of health care clinics is for activists to organize lectures, conferences or health fairs. One participant active since the 1960s said that in the beginning they were using the "conference as a social movement." She meant that their main strategy at the start of the movement was to educate the public. They would organize conferences that would unite speakers on a variety of issues or techniques such as acupuncture, and empower individuals to use alternative medicine. The activists also used the location of these symposiums as a strategy to gain credibility. In 1969 activists held a seminar on acupuncture for physicians at Stanford. The prestige of this institution gave credibility to the conference, even though Stanford did not explicitly sponsor this event (Otto and Knight 1979:21-2; conversations with several activists).

Activists continue to use conferences to educate the public. I observed the interest group plan and execute a one-day health fair to heighten awareness about alternative techniques and raise money for their organization. The all-day activities included celebrity speakers, a health fair and workshops on general wellness, women's health issues and children's nutrition. Physicians, chiropractors, lawyers, authors and counselors conducted workshops on the connection between the mind and body, as well as specific issues such as natural hormone replacement therapies. At the health fair visitors could learn about and try alternative techniques such as chiropractic and Reiki. Several hundred people attended the health fair and lectures. Similar events, such as the Whole Life Expo, illustrate that this is a common format within the alternative health care movement.

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17The Whole Life Expo offers product and book exhibits, services such as body work and clairvoyant readings and speakers on a range of topics. Organizers bring the exhibit to San
An activist tells me that to have a successful social movement you need "political know how." Clearly, this strategy of public education, especially at locations that lend credibility to the movement, shows much political knowledge and insight. Educational outreach at the local and national level helps to recruit activists and sympathizers, and develop communities to broaden the movement's reach beyond activism at the individual level.

Conceptualizing Personalized Politics as Collective Action

Practitioners and clients both see these personalized political strategies as activism since empowered individuals can eventually influence others and society. Similar to clients, a homeopath sees "activism as healing and teaching work - activating people from the inside out by practicing and teaching homeopathy. Joining a [professional homeopathic] organization is more outer preparation." Individuals create oppositional identities through these interactions (Schneirov and Geczik 1996:627; Taylor and Whittier 1992). Social movement communities allow individuals to experiment with "new authority patterns, new forms of organization, and new ideas" (Schneirov and Geczik 1996:638). Participants are also able to share stories and provide alternatives to dominant cultural codes about professional medicine within these social movement communities (Fine 1995; Lichterman 1996; Melucci 1985).

I show how we can conceptualize these seemingly individualized acts as collective action since so much activism within the alternative health care movement takes place at the individual level. Schneirov and Geczik (1996)

Francisco bi-annually, and annually to Atlanta, Minneapolis, Austin, Chicago and San Jose, California.

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identify four sets of changes that a person goes through upon adopting alternative medicine. First, clients evaluate their previous relationships with medical providers as they develop a relationship with an alternative practitioner. Second, friends and family have to adjust to the new practices these clients adopt. Third, clients increasingly associate with others who use alternative medicine since they understand these demanding practices. Finally, individuals create new "value commitments" as they interact with different individuals. All four changes make the person committed to a community and way of life, not just to a type of medicine. "Each change takes the person from the immediacy of everyday life to a connection with others and with larger issues, from illness as a private trouble to illness and health as social problems" (Schneirov and Geczik 1996:640).

Schneirov and Geczik (1996) identify the first change when clients develop a relationship with an alternative practitioner. Since these relationships are so different from the ones formed with physicians, clients begin to evaluate previous relationships with medical providers. Respondents in my study believed that alternative practitioners are more likely to listen to clients and spend more time with them. Individuals discover that they are not the only ones to have negative experiences in Western medicine by hearing stories from other clients and practitioners. They begin to see a connection to others. For example, some female respondents began to identify with other women and develop a feminist consciousness when they began to see their negative experiences in Western medicine stemming from their gender.

A client experiences the second stage when friends and loved ones have to get used to the new life demanded of these individuals. Alternative medicine often requires lifestyle changes, as we saw from the core beliefs, so
the person becomes increasingly different from these other individuals. "Identification with alternative health is not simply a 'belief,' but is rooted in an emerging way of life" (Schneirov and Geczik 1996:641). This can create conflict for these individuals. Many of my respondents do not get favorable responses from friends and family members. For one respondent there were such differences between her old friends and new practices that she "feared she would lose her friends" [from her scientific graduate program]. She did lose all but one woman who values their friendship, but still thinks "it's weird." Yet, these differences often strengthen their commitment to alternative health care as they compare their health to others and see the value in what they are doing. One client says "it's a tough path, but once you get on it, there's no going back. I wouldn't live that other way anymore." In this way their collective identity constructs a moral boundary.

Third, clients increase their associations with other individuals who use alternative medicine. The client begins to identify with an alternative health community, because these individuals understand the client's motivations and needs. When I described the various social movement communities I referred to the woman who started with the feminist gynecological clinic, but became more involved once she saw the strong bonds among members within the spiritual center. This networking also happens at conferences as I have described. As individuals identify and associate with others like them, they become part of a new alternative health community. One client explains that the "community or network helps to sustain you." This process of identification with other similar individuals also leads to more of a collective orientation. Clients create oppositional identities through their interactions with practitioners, because they share
stories that show others have similar experiences. They also present alternative ways of thinking and acting that include collective forms of action.

Fourth, the person creates new "value commitments" since she or he interacts in the movement with diverse individuals. For example, one-third of the activists in Schneirov and Geczik's (1996) sample also identified as feminists (641). Participants develop new oppositional identities that also have a collective orientation, or suggest collective forms of action. Similar to their finding, several of my respondents identified with feminism. One woman said feminism and alternative health care "compliment each other."

These individualized actions have political consequences for the movement. As I have stated, activists often spread the word about alternative medicine to friends and family. By sharing information they hope to empower and recruit other activists. Yet, they also tell their insurance companies to cover these techniques. As more individuals do this, we begin to see insurance companies make changes in their reimbursement policies (refer to Table 4.1). This, in turn, stimulates more acceptance for these techniques and the movement.

Schneirov and Geczik's analysis does not explain the connection between personalized political strategies and the political context. Respondents believe that using and practicing alternative medicine are a form of activism because of the political context. The political environment constrains tactics (Gamson 1990/1975; McAdam 1983; Morris 1984) and cycles of protest (Tarrow 1993). Once you become a member of the interest group I

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18Basic membership requires twenty-five dollars for annual dues. Members may also pay $75 to become a benefactor, $150 to become a sponsor or $500 to become a patron. There are different benefits associated with each level of membership. For example, you must pay at least $75 to receive the national faxes. Sponsors receive additional discounts on products and special events. The national organization provides patrons with special reports on legislative matters.
observed, the welcoming letter suggests that grassroots activism is more successful than political action committees or paid lobbyists in the 1990s. One of the national organizers echoed this sentiment when he said that if you pressure the Presidential candidates enough, you can outweigh the money behind political action committees with votes. To support this, the interest group’s written materials include Margaret Mead’s suggestion to “never doubt that a small group of thoughtful, committed citizens can change the world; indeed it is the only thing that ever does.” One way to raise this awareness among individuals is to use or practice this form of medicine. Publications such as Bay Area Naturally reiterate these ideas. The editor Jerome Rubin writes, “what is most essential in creating global change is to make the small, individual changes that we can each make each day, one step at a time” (Fall 1997/Winter 1998:3).

Schneirov and Geczik (1996) also fail to highlight differences between the strategies clients and practitioners use. Clients primarily change themselves. Lichterman (1996) defines people that contribute to social change by changing their inner self as therapeutic activists (36). Recall that Schneirov and Geczik (1996) argue that clients embody their opposition to Western medicine through personal practices such as what foods they consume (638). Practitioner’s strategies involve changing others. This difference in focus or target means that practitioners and clients will engage in the same tactics differently. Empowerment is critical. Clients attempt to empower themselves first and then others while part of the practitioner’s job is to empower others. The practitioners may have empowered themselves first. Yet, their tactics involve empowering others. It is part of their job; whereas,
clients are primarily consumers. Among other factors, Freeman (1979) argues that available resources and constraints determine strategies. Practitioners should have an easier time empowering others, because many clients come to them for this reason. Clients, on the other hand, do not have access to this resource, or group of ideologically committed people. Also, clients may have difficulty empowering others when many are ill and need to focus on themselves.

**CONCLUSION**

All respondents in my study believe there is an alternative health care movement, and most (87%) identify as activists within it. These individuals have turned their individual experiences with Western and alternative medicine into activism by developing shared understandings or a collective identity. Collective identities emerge as participants draw boundaries, create political consciousness and politicize everyday life. Together, these three processes enable activists to turn personalized forms of resistance into collective action to promote social change — a necessary component of a social movement. Similar to Taylor’s (1996) analysis of the postpartum depression self-help movement, individuals use and practice alternative medicine as a way to promote social change. Collectively these activists highlight problems with the existing institution of Western medicine, offer an alternative model, encourage personal and political changes in participants, and lobby for legal, political and social changes. All of these strategies promote social change, thus the activists who use them are part of a social movement.

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19 Freeman (1979) adds that the structure of social movement organizations, values, ideologies and expectations about potential targets also influence strategies.
Personalized political strategies are a strategically effective way to keep the movement afloat given the nature of health activism and the political context. Hoffman (1989) argues that many individuals only seek health care when they are sick, and unable to be active in a social movement. Yet, many of my respondents turn their quest for health into activism. They focus on empowering and healing themselves so that later they can do the same for others. This provides a continual supply of activists for the movement, all at different levels and types of participation. Likewise, more individualized forms of activism result from the political environment (McAdam 1983; Taylor and Rupp 1993; Whittier 1995). One client says, "I think it would be really nice if people change, but there is a lot of resistance. What we can do in little ways is important [such as having] awareness in our individual lives." Maintaining commitment and awareness provides a resource for future mobilizations (Taylor 1989).

Movement ideology forms a critical component of collective identity. Some individuals joined the movement because they began to agree with the core beliefs. In this way, a strong ideology facilitates recruitment (Dalton and Kuechler 1990; Fantasia 1988; Taylor and Whittier 1995). These beliefs provide the key separation between alternative and Western medicine. Identification with this ideology, then, encourages consciousness and collective action. Activists have diverse experiences with alternative medicine -- some are sick, others provide services -- so ideology also unites otherwise disconnected individuals. It is the strength of these beliefs that allows activists to develop and maintain their collective identity. This is particularly important for the activists in this chapter because they challenge
Western medicine through their construction of an alternative model. A strong collective identity supports their outsider status in a hostile political environment.

I now turn more closely to the connection between collective identity and the political opportunity structure. The collective identity of alternative activists focuses primarily on changing individuals. Activists pursuing integrative medicine form a collective identity that focuses more closely on changing institutions. The collective identity has changed since new political opportunities have arisen.
<table>
<thead>
<tr>
<th>COMPANY</th>
<th>THERAPIES COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna U.S. Health</td>
<td>acupuncture, chiropractic, nutrition counseling</td>
</tr>
<tr>
<td>Alternative Health Insurance Services</td>
<td>acupuncture, alternative birthing centers, ayurvedic, biofeedback, bodywork, TM, chelation therapy, chiropractic, colon therapy, herbal medicine, homeopathy, naturopathy, nutrition counseling, oriental medicine, osteopathy</td>
</tr>
<tr>
<td>American National</td>
<td>acupuncture, chiropractic, massage, nutrition counseling for diabetes</td>
</tr>
<tr>
<td>Blue Cross of California</td>
<td>acupressure, acupuncture, biofeedback, chiropractic, Dean Ornish program</td>
</tr>
<tr>
<td>Blue Shield</td>
<td>acupuncture, chiropractic, fitness, health spas, massage, somatic education, stress management</td>
</tr>
<tr>
<td>CIGNA HealthCare</td>
<td>acupuncture, biofeedback, chiropractic, nutrition counseling</td>
</tr>
<tr>
<td>Co-op America</td>
<td>chiropractic</td>
</tr>
<tr>
<td>CUNA Mutual Group</td>
<td>chiropractic, biofeedback, nutrition counseling</td>
</tr>
</tbody>
</table>

Source: This list was adapted from the *New Age Journal* (Spring 1997:67-68).

Table 4.1: Selected Insurance Coverage of Alternative Techniques

(continued)
<table>
<thead>
<tr>
<th>COMPANY</th>
<th>THERAPIES COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fortis Benefits</td>
<td>acupressure, acupuncture, biofeedback, chiropractic, massage</td>
</tr>
<tr>
<td>Guardian Life</td>
<td>naturopathy</td>
</tr>
<tr>
<td>John Alden Life</td>
<td>acupuncture, chiropractic</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>acupressure, acupuncture, nutrition counseling, relaxation techniques, self-massage</td>
</tr>
<tr>
<td>Mutual of Omaha</td>
<td>acupuncture, Dean Ornish program covered in selected states, naturopathy</td>
</tr>
<tr>
<td>New England Mutual Life</td>
<td>acupuncture, acupuncture, chiropractic</td>
</tr>
<tr>
<td>Pacific Mutual Life</td>
<td>naturopathy</td>
</tr>
<tr>
<td>Phoenix Home Life/</td>
<td>acupuncture, biofeedback, chiropractic, nutrition counseling</td>
</tr>
<tr>
<td>Phoenix American Life</td>
<td></td>
</tr>
<tr>
<td>Prudential</td>
<td>acupuncture, biofeedback, chiropractic, massage, midwifery, naturopathy</td>
</tr>
<tr>
<td>UniCare</td>
<td>biofeedback, chiropractic, and if administered by an M.D., acupressure, acupuncture, naturopathy</td>
</tr>
<tr>
<td>World</td>
<td>naturopathy</td>
</tr>
</tbody>
</table>
CHAPTER 5

COLLECTIVE IDENTITY OF INTEGRATIVE MEDICINE:
CHANGING INSTITUTIONS

Many health movements, such as holistic health care... 
[are] not directed at changing the state or an institution. 
Holistic health movements will have little impact on 
the state, nor do they seek it. They are dissenting 
movements within medicine, but do little to change 
professional medicine, develop new state laws, or 
protest current medical or hospital practices. They 
become arenas of action with little direct conflict with 
institutions. They are alternatives to professional 
medicine; they are not movements to change the medical 
institutions. In a sense, then [sic] bypass rather than 

Many of the activists in the previous chapter are competing with 
Western medicine, and their collective identity reflects their status as 
“outsiders” or “anarchists”; however, the activists in this chapter are 
developing an integrative medical model that includes physicians. The 
political context is becoming more conducive to integrating alternative and 
Western medicine. Financial and organizational changes in Western 
medicine, such as the onset of managed care, frustrate consumers and 
physicians alike. Physicians are becoming interested in integrative medicine 
given their dissatisfaction with structural changes that erode their authority 
and threaten their client base. At the same time, we may be witnessing a 
closure of the political opportunity structure to alternative models. Most
physicians that turn to alternative medicine do not abandon their Western training or techniques. These physicians are assisting activists with an "integrative" model of medicine, rather than the "alternative" system Gusfield (1994) suggests. As the political context changes and physicians join the movement, the collective identity is changing.¹ Activists are opening their boundaries to include physicians within the movement, changing their political consciousness and influencing institutions not just individuals.

Aakster (1986) calls this new medical model an integrational model, because it attempts to bridge Western and holistic medicine by combining the best of both. Many alternative practitioners believe Western and alternative medicine are complimentary, since the former deals better with acute or crisis care while the latter is more successful with chronic conditions (Mattson 1982:138). Activists deliberately aim for integration with Western medicine in order to gain credibility. How is an integrative model of medicine different from both Western and alternative models? What political changes have taken place that allows activists to choose this strategy at this point in time? How does this change the collective identity of activists? Does the ideology stay the same? What are some of the issues that arise as alternative practitioners and physicians develop this model of medicine, and how successful will they be?

Some resource mobilization theorists explain that social movements arise and decline depending on the political opportunity structure (Jenkins and Perrow 1977; McAdam 1982; Tarrow 1994; Tilly 1978). Tarrow (1994) defines the political opportunity structure as "consistent-but not necessarily

¹I use the word "changing," rather than "changed," for two reasons. First, integrative medicine is an emerging trend so the collective identity is just beginning to change. Second, I attempt to answer Melucci's (1995) call to examine collective identity as a "processual," rather than "reified" part of movements.
formal, permanent or national-dimensions of the political environment which either encourage or discourage people from using collective action" (18). Factors external to social movements, such as support from the government and political elites, comprise the political opportunity structure. Activists gain access to a variety of resources when the political opportunity structure becomes more favorable, either through the receptivity or vulnerability of inside groups or political and economic systems. For example, political opportunities arise when influential allies make themselves available to activists or cleavages are created among elites (Tarrow 1994). I use the idea of political opportunity structure to explain why activists have been able to change their strategy from providing an alternative model of medicine to creating an integrative model that combines Western and alternative medicine. The authority and dominance of Western medicine are beginning to dismantle, and this has led to a more favorable political opportunity structure for activists within the alternative health care movement. We need to understand these changes so that we can see why the goal of integrative medicine is increasingly possible.

Contemporary social movement theorists are examining the relationship between the political opportunity structure and collective identities, which helps us understand why the collective identity of the alternative health care movement is changing. Taylor and Whittier (1995) argue that we cannot understand cultural elements such as collective identities without simultaneously studying structural elements such as political opportunities (34). Activists develop collective identities within "a system of opportunities and constraints" (Melucci 1995:47). Ideas and identities are enabled or constrained by access to resources and power. For example, movements that have greater access to the mass media, a key
resource for activists, can spread their message or "master frame" to a larger audience and gain sympathizers or participants in the process (Snow and Benford 1992). Activists within the postpartum depression self-help movement have relied on their access to national talk shows to enlist supporters and enact societal changes (Taylor 1996).

One line of research linking the political opportunity structure and collective identities examines whether activists open or close their boundaries during hostile political climates. Joshua Gamson (1995) argues that theorists need to question under what political conditions social movements need a stable collective identity. He suggests that closing group boundaries, one element of collective identities, is a necessary survival strategy. Taylor (1989) argues that social movement organizations can act as "abeyance structures" sustaining a movement during a "nonreceptive political environment" (761). Though the movement operates on a smaller scale, activists sustain a collective identity that gives them a sense of purpose. Activists focus on maintaining their commitment, rather than recruiting new participants. Taylor's research illustrates how feminists in the National Women's Party survived the hostile period between the 1920s and the 1960's by closing the boundaries of their collective identity. Whittier's (1995) work, on the other hand, shows that feminist boundaries became more permeable during the abeyance period in the 1980's and 1990's.

My research shows that activists gain access to institutions if they open these boundaries during more favorable political climates. Collective identities can be "disembedded from the context of their creation so they are recognizable by outsiders and widely available for adoption" (Taylor and Whittier 1995). Friedman and McAdam (1992) warn against this. They argue that social movements should restrict access to their collective identity,
because activists can then control it as a "selective incentive" or enticement to participate (165). If activists do not restrict access, individuals may continue adopting the collective identity, but do this without participating in the social movement. "Their very success in disseminating the collective identity undercuts their basis of existence, and the movement will die for lack of participation" (169). Quite the contrary, I believe that opening access to the collective identity to new participants, even physicians, enables an integrative model of medicine to emerge. This gives the movement access to a variety of resources and level of success previously unimaginable. The key is that activists need to maintain control of the ideology, or one of the key components of their collective identity.

Activists pursuing integrative medicine cooperate with mainstream groups such as physicians and hospitals. Ferree and Martin (1995) argue that new social movement theory downplays social movement organizations that work with conventional institutions, because theorists believe these activists are "co-opted or inconsequential" (11). Typically movements do not organize and act within mainstream political institutions or with conventional forms of action. Activists tend not to have access to these, and they fear co-optation if they did (McAdam and Snow 1997:326). Although some clinics incorporate Western and alternative medicine on equal footing, many researchers would argue that this integrative model is one where Western medicine simply co-opts alternative medicine (Easthope 1993:299; Goldstein et al. 1987: 106, 118; Haas 1992:3; Lowenberg 1989:7). Some physicians just want to learn alternative techniques to retain for their practices, while others desire to work with alternative practitioners in an integrative setting. However, it is too early to tell whether Western medicine will co-opt alternative medicine overall. Most activists said it will take fifteen to twenty years before we see
how integrative medicine evolves. In this chapter and the next I summarize my argument as to what might happen as the movement attempts to institutionalize its techniques and practices, though.

The question on activists' minds is not whether integrative medicine will exist in the future, but what it will look like. Dr. Woodson Merrell, assistant professor of medicine at Columbia University, suggests that "the integration of alternative and traditional Western medicine is the medicine of the future" (Cosmopolitan September 1997:313). Since this is an emerging trend, I explore why this strategy is suddenly available to activists. Also, what are the possible outcomes? Will physicians simply co-opt specific alternative techniques, or will physicians and alternative practitioners work together as partners to practice integrative medicine?

These research questions highlight tactical interaction between a movement and its opposition, and how the strategies and collective identity of the alternative health care movement change over time (McAdam 1983; Melucci 1995). In the beginning of a movement, activists need to assert their differences with existing models in order to convince the public that they provide a better alternative. A client explains that "in the early phase of social movements you have to justify yourself, and you put someone down to do that." English-Lueck (1990) argues that in the beginning the alternative health care movement defined itself narrowly, so their position did not threaten orthodox medicine (150). At this stage, the movement identified as "alternative," or "complimentary" at most. Over time, the possibility of "integration" opens up as the group in power begins to take the opponent more seriously, and make concessions to their demands. Activists no longer identify as alternative, but integrative, since they have new opportunities to
influence the structure of Western medicine. I address potential problems that activists and consumers might experience as alternative medicine moves to become institutionalized.

I describe integrative medicine before I examine changes in the political opportunity structure and collective identity, since an integrative model is so new. I use data from interviews with members of an integrative clinic and observations of a professional organization to describe this model.

FEATURES OF INTEGRATIVE MEDICINE

Practitioners are developing an integrative model of medicine. Clients need multiple therapies to heal the mind, body and spirit as holistic ideology dictates. Yet, it is more practical for several practitioners to work together in one setting in order to heal clients rather than to have one practitioner try to learn numerous healing modalities. Integrative clinics are different from solo practitioners sharing office space, because practitioners work together as a team and include Western practitioners. Clients benefit from an integrative approach, yet they must take an active role in their healing.

Practitioners are developing integrative medicine for ideological and practical reasons. Holistic ideology states that practitioners need to use multiple therapies since they address so many facets of the person, and do not believe that illness has a single etiology (Alster 1989:61). The director of the integrative clinic explains that these practitioners recognized “their limitations.” “I think a lot of these groups are forming to combine resources and cover more of the bases. We recognized that people need the whole spectrum [of resources] to get better and stay that way.” Practically, practitioners and activists know that clients want both Western and alternative medicine, and benefit most from this combination. Western
medicine is useful for diagnosing and monitoring conditions as well as treating acute crises such as broken bones or infections. Western medicine’s best “tools” are drugs and surgery, yet there are limits to relying on these solely. Alternative medicine is better for chronic illnesses or those illnesses where lifestyle plays a role. A combination of Western and alternative medicine, or integrative medicine, is more beneficial than choosing either one exclusively. One client says she wishes “Western and alternative medicine could mix more. I don't see it as black and white, or good and bad, just as complimentary. Both sides are weary of the other, but I think there is a place for both.”

Integrative clinics use Western and alternative techniques within the framework of holistic ideology. It is difficult for integrative clinics to select staff members given the need for practitioners to use these principles to guide their practices. It took several years to figure out what type of practitioners the integrative clinic needed, and to find the right people. The director of the integrative clinic explains why this was difficult.

If you get into what I call a truly holistic way of seeing the world, practices come out of that. It will include holistic methods, but it's more how you approach a problem, and asking what does the person need in a holistic way as broadly and deeply as possible. Just to do that evaluation you need a lot of perspectives. Another aspect is you have to have people who get this approach well enough so that they can start to work in it. That's been a big challenge, because it's a new way of thinking. Even if you were trained as an acupuncturist where it's inherently holistic, you can be using it [in a] Westernized [way]. They're still thinking symptoms. You can't just use a holistic tool in the other way. You won't get results. [You need] to really start thinking and acting according to holistic principles. It's a high calling in my opinion. So you get people that have embraced this genuinely in their lives and understand it.
Another practitioner in this clinic agrees that "there are different gradations [of using a truly holistic approach, because] we are all attached to conventional medicine in a certain way." After a clinic finds the appropriate practitioners they have to learn how to work together as a team.

**Developing a Team Approach**

Staff in the integrative clinic suggest that finding practitioners that can work together as a team has been one of their biggest challenges. For an integrative model of medicine to be successful, activists need to develop a team approach where each practitioner has a similar amount of power, because holistic ideology shows that each approach is equally useful. In these clinics, the practitioners have to work as a team, which requires letting go of the authority, autonomy and exclusivity that often accompanies a professional status (Tubesing 1979:128, 147). Perhaps explaining why the majority of the practitioners in the integrative clinic are women, the director finds that:

- women find it easier to not have to be the one in charge of calling the shots. We are striving to be a team here. It's laborious, and it takes people letting go of their control. All of us practitioners, especially physicians, are used to being in control of that patient. We have the final word. The more traditional you get, the more gender seems to matter. So say with therapists, generally the more traditional it is, it seems the less the men have been attracted to being involved with the group.

An integrative clinic needs practitioners who can communicate, not just forsake their "ego" and control. The director of the integrative clinic explains why this is difficult.
Each discipline has their own vocabulary, [and] their own set of principles they are operating on. How do you get these people to really understand, appreciate, and [know] when to use each other? Well, we are tackling this by doing it. We are developing a common language. We're meeting together, and educating each other. We're having case conferences, and experimenting basically. All of us are pretty familiar with what results we can get on our own.

Likewise, the professional organization spent the first eighteen months trying to understand and educate each other. Members said this involved “defining our identity.” The culmination of this educational process was a professional symposium where members spoke about various alternative techniques and approaches. One member says, “they’ve been preparing for the symposium, but prior to that they tried to promote communication between practitioners of different modalities. That’s more informal.” This process was extremely difficult since practitioners typically have a different belief system, set of guiding assumptions and language underlying their work. The process of educating and learning how to communicate is far from over for these groups. These communication difficulties do not just lie between physicians and alternative practitioners. One member said that the organization helps alternative practitioners become familiar with each other’s work since they are not necessarily knowledgeable about other alternative techniques.

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2During several workshops speakers would use medical terms that many alternative practitioners would not necessarily understand. One speaker, a physician, mentioned that a client had a “MRI.” He then said, “most of us know what this is.” He never explained anything further. It is true that many lay people would be familiar with this term, but not necessarily the science behind how physicians use it and what the results mean. This was only one example where members used Western medical terms without defining them, and most other examples used much more technical terms.
Once practitioners have developed a common language they need to learn how to work together on individual cases. The integrative clinic plans to have several practitioners interview the client at once, and then consult with each other to make treatment recommendations. Since the director of the integrative clinic is a homeopath, which entails an exhaustive intake process, he will “function as one of the overview practitioners [who] sees people for the first time.” The physician will also play this role since Western medicine is particularly good at diagnosing and ruling out medical conditions. Clients will choose their treatment plan after practitioners present several options and announce their preferences. Practitioners would continue to evaluate and monitor a client’s health and treatment program through team conferences.

The integrative clinic has not fully implemented this team approach in practice. They have been informally scheduling team conferences, but would like to make this process more formal. One of the practitioners believes that they are farther along with educating each other, rather than “working in a true team process.” As it stands now, the practitioner who has the initial contact with the client acts as the primary provider. Other practitioners might become involved in the case; however, as a “courtesy” they should consult with the primary practitioner first. This model is closer to managed care than the integrative model activists desire. Practitioners have not worked out details of the team approach because it is so difficult.

Members of the professional organization are finding similar difficulties developing a team approach even though their organization does not act as a clinic. Members of the professional organization are developing a team approach through examining individual cases, and seeing how multiple practitioners would help the client. They have plans to look at AIDS and
chronic fatigue syndrome, for example. "I think taking cases is a good direction. It really focuses things so we don't just talk about vague generalities." Yet, during some workshops the presenters seemed to talk past each other, rather than have a true dialogue. They would most often raise more questions than answers. One presenter at the symposium said "none of this is easy, but none of this is impossible." Some members have come away from these meetings no longer believing it is even possible. Most of the others lie somewhere in the middle. A member of the audience at one of the workshops said that there has been a "great deal of hostility on both sides historically." She can say that integration is "plausible" after participating in this group.

An integrated team approach to health care is rewarding for practitioners even though this coordination is time consuming, difficult and goes against much of one's medical training (Tubesing 1979:128, 178). The director of the integrative clinic suggests that their work entails "very new territory, [which] is part of the excitement that draws practitioners to us." He believes that the biggest advantage to their approach is the "synergy that can happen." The chiropractor likes the "camaraderie." He explains that if he is "having a problem with a patient I can ask other practitioners [for] suggestions. You get a perspective totally different from one you would have imagined. I've learned a lot about other modalities." The nurse practitioner agrees that the camaraderie is the biggest advantage to the team approach. "My sense is that we appreciate hearing each other's input, and that we are learning something [with] every kind of medical dialogue. It keeps it exciting."
Aside from learning other techniques and perspectives, a team approach to health care allows activists to form strong bonds with one another. The director of the professional organization said that the “content is obviously important, but it’s working together in a holistic way” and connecting with each other that are more important. He says that this requires patience with ourselves and others that are not yet open to integrative medicine, especially physicians. At one of the organization’s workshops a physician said that he finds it “scary” to discuss alternative techniques, because their logic often falls outside the realm of his Western training. A chiropractor responded that this physician’s comments showed a “display of courage that this [organization and movement] are all about.”

Role of Clients

Clients experience many advantages in integrative clinics, as well as new responsibilities. Clients benefit from the increased diagnostic and treatment options in integrative clinics. Clients contrast this with Western medicine, which they believe does not offer enough options besides drugs or surgery and neglects self-help remedies. Clients appreciate that they can get both alternative and Western medicine, “one lending credibility to the other depending on your bias.” “It’s one-stop shopping here.” Some consumers may have more confidence in alternative techniques since they see that physicians support these practices (Starr 1982:424). They benefit from the better care since practitioners are accountable to each other in a team setting. The chiropractor says clients appreciate that a “lot more time is spent with the patient. We try to look at the patient as an individual, and what their individual needs are from a holistic perspective.” “They feel well cared for
and listened to, which validates them as human beings." Clients have to be willing to take responsibility for their health; however, physicians attract some clients to integrative clinics that are less willing to do this.

We have seen how practitioners work together, but it is also necessary to examine where clients fit into integrative clinics. "The [integrative clinic] works as a team in partnership with the patient and their other health care providers...involving individuals and remaining responsive to their needs" (flier).³ This means that clients need to take responsibility for their health, as holistic ideology dictates. Members of the integrative clinic acknowledge how difficult this is for clients. One of the directors of an integrative clinic told me a story about a monk who studied in silence, and finally consented to an interview with a man who asked him if he had witnessed miracles. The monk said "yes, I've seen myself change." She explained that the moral of the story is that practitioners know how hard it is for people to change and take responsibility for their health and lives.

Though most of the clients in the integrative clinic are willing to take individual responsibility for their health, some are more responsive than others. The integrative clinic is able to attract a broader clientele than alternative practices since they have a physician and nurse practitioner on their staff. Practitioners in this clinic want to serve "the mainstream," not just "the Birkenstock crowd." However, practitioners have found that they have to be more conservative with "allopathic patients." These are individuals that come to their clinic for Western medical services only. The physician tries to educate these individuals since she is usually the only one to see them, but they are less likely to take responsibility for their health and

³As opposed to Western physicians, clinic practitioners do not discuss patient "compliance," because this assumes the patient is passive.
they are more "demanding." Many just want medications without paying
directly for services. This clinic has found it necessary to restructure their
reimbursement policies to get these individuals to become actively involved.
Practitioners have clients pay before they provide any services. Staff find that
unless clients pay directly for services, they are less likely to take responsibility
for their health.

Practitioners are able to raise awareness in most people that come to
the integrative clinic. The majority of the clients come to the clinic for a
specific problem.\(^4\) Despite the fact that they "emphasize prevention and self-
care," the chiropractor estimated that only ten to twenty percent of his clients
see him for prevention alone. "More and more it's average people who have
[become] disillusioned with the mainstream approach. They've read an
article or heard a few things [about alternative medicine], and figured what do
I have to lose." These individuals find this clinic specifically through "word
of mouth." Chiropractic, homeopathy and women's health care bring clients
in to the integrative clinic more than the other techniques. In the beginning
most come for one specific technique, rather than the variety of practitioners.
The director estimates that more than 50% are skeptical of alternative
medicine or are cautious at least. Once introduced to the clinic and the
diverse approaches that are available, most clients utilize numerous services.
For example, one-half of the chiropractic's clients have used acupuncture.
Most physicians are just as cautious about alternative medicine, so it is
important to examine why physicians are suddenly interested in an
integrative medical model.

\(^4\)Overall, clients are drawn to this clinic for "effectiveness the most, ideology the least." After
I distinguish between coming in for prevention or a specific problem, this respondent agreed
that if you come for prevention you are drawn by ideology. If you come for a specific problem
you are probably drawn by effectiveness.
POLITICAL OPPORTUNITY STRUCTURE

Structural changes in Western medicine diminish physicians' power and authority; however, physicians still have more power in our society than alternative practitioners. Given these power differences, why would physicians risk their careers to join the movement? Are physicians trying to integrate on equal footing with alternative practitioners, or are they simply learning alternative techniques to retain their clients? I address these questions by examining changes in the political opportunity structure.

In various ways Western medicine is falling from its pedestal. There are many factors that make Western medicine susceptible to criticism and change. I begin by briefly highlighting how physicians gained their power, authority and dominance during the twentieth century so that we can see how dramatic the recent changes in the political opportunity structure are.

Starr (1982) provides the most comprehensive explanation of internal and external factors that allowed physicians to gain power. Internally, growing specialization and the growth of hospitals made physicians more cohesive and less competitive amongst each other (18-20). This strengthened their power as a group. Externally, urbanization made consumers rely on strangers for care, not the town doctor. New insurance policies forced many consumers to utilize physician's services since these companies limit payments to physician care (Mattson 1982:41). Consumers now had to rely on institutionalized licensing and education to evaluate their physicians, rather than the credibility of the physician's character (Starr 1982:18-20). Physicians soon gained control over these aspects of their profession.

Mattson (1982) adds that increasing reliance on professional medical care is due to the dissolution of the extended family (41). We are no longer able to rely on the older generation's medical knowledge; moreover, we began
to distrust lay medical knowledge in favor of scientific knowledge. The belief in science shifted the burden of health care to the doctor, especially after World War II (Mattson 1982:41). In this scientific model, health becomes defined as a “complex matter requiring expert intervention” (Weitz 1996:228). Western medical doctors became the “experts” because they were able to monopolize scientific knowledge.

The Flexner Report, published in 1910, highlighted the “lax requirements and poor facilities” of many medical schools (Weitz 1996:229). Consequently, the government closed many schools and improved the others through the passage of strict state licensing laws. Medicine became dominated by white, middle class men, which is a group that the public and legislators thought were credible (Weitz 1996:229). This can explain the final factor in the creation of professional dominance. Groups such as the American Medical Association (AMA) were able to restrict their competitors. Legislators accepted and legalized their claims to autonomy and dominance since they shared a similar social position as the physicians (Weitz 1996:227, 229).

As a profession, physicians have the autonomy and power to set their own standards and self-regulate (Freidson 1970:84; Weitz 1996:230). “Until recently, [scientific medicine] has exercised dominant control over the markets and organizations in medicine that affect its interests” (Starr 1982:5). However, physicians are losing their dominance for a variety of reasons. Here I outline three major reasons. These are much more important to our understanding of why alternative medicine is increasingly gaining a foothold with the public and physicians.
There is an "apparent loss in a single decade of the authority that medical professionals held for much of the twentieth century" (Mick 1990:xiii). Several trends threaten physicians' autonomy and dominance. These trends have taken place in the last fifty years, and increasingly during the last twenty (Mick 1990; Scott 1993). Overall, the medical environment is increasingly complex (Gray 1986:172). There is no longer a single, dominant group or figure in the medical industry; whereby power has moved away from the physicians to the medical schools, hospitals, health insurance companies, health care chains, financing and regulatory agencies (Starr 1982:8, 421). Now the medical sector resembles other economic sectors that are subject to market pressures. This contrasts with previous periods when physicians exemplified unparalleled power and authority (Scott 1993:281).

The only exception to this trend toward growing similarity with other economic sectors is the growing influence of the government that still sets the medical sector apart (Scott 1993:278). Before the 1940's, the government's main influence was through certification of practitioners. Now, many consider the government the "principle player in the field," since they are the largest purchaser of medical services (Scott and Backman 1990:5-6, 32). The government establishes rate setting commissions that limit the amount they will pay for health care. The government's purchasing power will only increase as our population ages, since government Medicare programs attempt to provide coverage for our elderly. The increased role of the government tends to diminish the control physicians have over health care policy. Federal programs such as Medicare and Medicaid make health care a lucrative business, which increases the scale (Weitz 1996:237).
Second, some observers have noted the increased scale of health care, as measured in dollars and the number of providers (Scott 1993:275). By 1984 health care became the third largest industry after food and housing, accounting for approximately 12% of the gross national product (GNP) in the United States (Anderson as cited in Scott 1993:275; Mick 1990:4). There has also been unparalleled growth in hospitals (Mick 1990:5). The average number of beds in hospitals rose from less than 100 in 1940 to 173 in 1991 (American Hospital Association statistic cited in Scott 1993:276). Though there are a variety of reasons for this increased scale, one example is that consumers now want the best modern medicine can provide so they demand more services and the use of expensive technologies (Scott 1993:275).

Investors became interested, since health care became lucrative for providers due to this increased scale. We began to see hospitals as corporate chains and for-profit insurance companies after the changes noted above (Starr 1982:428). In 1983 U.S. Health Care Systems became the first health maintenance organization (HMO) owned by investors. By the mid-eighties one-third of all HMO's were for-profit (Bloom 1987:52-3). Today, twelve large corporations (e.g., Kaiser, CIGNA, Blue Cross/Blue Shield) account for most HMO memberships (Bloom 1987:91).

We have seen changes in ownership and control, specifically toward more concentration, now that health care is profitable (Scott 1993:275; Starr 1982:429). Private companies increasingly own and control health care organizations. For example, hospitals are now part of corporate organizations (Scott 1993:275-279). The locus of control moves away from freestanding, local structures and individual physicians to nonlocal, multilayered authority structures (Mick 1990:2; Starr 1982:429).
The new players in the health care field brought with them a market orientation that focuses on financial outcomes (Scott 1993:280). This change increases managers' power, and decreases physicians' power within medical institutions (Gray 1986:172). Earlier theorists thought health care was immune to market pressures (Scott 1993:280). Now we are seeing changes within medicine that reflect the opposite. At a basic level, the language has changed from discussing a medical care system to a health care industry (Mick 1990:6-8; Scott 1993:280). One physician says that medicine has become an "explicit business." This new language reflects how profit, efficiency, rationality and consumers have taken center stage. To maximize profits, HMO's and other insurance companies are changing their reimbursement policies (Mick 1990:4). Many physicians find themselves trying to make their diagnosis fit the company's reimbursement policies, or having an administrator question their professional judgment (Weitz 1996:237). Physicians, then, become more dependent on financial managers due to these fiscal controls (Scott 1993:279-80).

Third, managers are gaining influence within health care settings at the expense of physicians (Scott 1993:279). Since the environment is increasingly complex and competitive, business professionals often manage health care facilities (Gray 1986:172). We assume corporations are better able to handle the complexity of the environment where health care facilities now operate (Scott and Backman 1990:34). Managers assume more power and control since the emphasis is increasingly on profits. Also, hospitals and other health care facilities are more likely to assume financial risk for a physician's decisions. Managers are more interested in assuming control due to the dramatic increase in malpractice suits. New data systems allow managers to monitor physicians more closely (Gray 1986:172).
Many researchers suggest that physicians are more compliant now so they acquiesce to these changes. Most importantly, there is an increased supply of physicians (Gray 1986:174; Mick 1990:5; Scott 1993:279-80). One reason for this increase is the influx of foreign students entering the United States for medical education and practice (Mick 1990:6). Individual doctors lose their bargaining power as the number of physicians increases. Physicians are also more complacent due to the hospital's ability to hire and fire physicians, and the reduction of hospitals where they can practice. In addition, increased loans from medical education and increased costs due to fear and prevention of malpractice force physicians to look for job security in hospitals and HMOs as opposed to private practice.

Many physicians become dissatisfied since these structural changes erode their autonomy and dominance. Physicians in Louisiana are even trying reclaim their hospital's non-profit status by buying Columbia/HCA Healthcare Corporation's share, because they are tired of the "bottom-line mentality" that is interfering with their professional work (McGinley 1998:A1). One member of the professional organization discusses how these changes impact physicians.

I think managed care increases the frustration for MD's. It's forced them into a number of directions. For example, they are under time restraints where they can't treat people. They just have to give a quick pill. There is no push to keep people healthy. It's a sick care system. That's not a system that's going to keep working. You can't expect insurance to keep paying for expensive procedures in a person's last year of life. So the MD's are forced to hand out pills. They realize the side-effects that go along with those. They are unhappy with that. There is pressure from patients. So a large population of people are saying they aren't happy, questioning doctors, and wanting to stay well.

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I would argue that there are no clear-cut ways to rectify the situation since the attack is coming from so many angles. This can lead to internal dissension within the medical community, but this only worsens the situation. Internal dissension that becomes public threatens the cultural authority of the profession, and allows alternative models to gain legitimacy (Wolpe 1990:914). Alternative practitioners have been able to gain prominence, in part, due to the weakened position of physicians. Yet, some physicians are turning to integrative medicine as a solution to their dissatisfaction with Western medicine and managed care.

My research suggests that physicians pursue integrative medicine for ideological or financial reasons given the political changes affecting Western medicine. I keep these reasons analytically distinct even though they are not mutually exclusive. Just as alternative medicine becomes attractive to consumers, some physicians may begin to see holistic ideology as a mechanism for improving upon weaknesses in Western medicine. It is unlikely that physicians would abandon their knowledge to learn a new alternative technique. These physicians also realize that Western medicine is useful in some cases. Consequently, some physicians may simply refer their patients to alternative practitioners while others may change the way they practice Western medicine.

First, physicians might recognize their limitations and refer patients to alternative practitioners. A dance therapist has seen a change in physicians’ reactions. She says that physicians have learned that “nothing works universally.” One client says her physician feels frustrated when she cannot help her clients medically.

She says the hardest thing as a doctor is to have this revolving door of a number of patients [where] all [she] can do is give painkillers or some kind of maintenance
drug. For example, doctors can do very little for people with backaches. They can help the patient get over this bout of back pain, [but] it's back in six months; [whereas,] many of the alternatives help people to get rid of that on a permanent basis.

Physicians might begin to see their techniques as only one method of healing patients, and refer patients to alternative practitioners. The patient benefits from multiple healing modalities, but does not necessarily receive integrative care since the practitioners may not consult with one another. In addition, the patient may only learn about holistic ideology through the alternative practitioners, not the physician.

The second option is that physicians driven by holistic ideology would change the way they practice medicine. These physicians are in the minority of physicians as a whole, says one respondent who is a physician. A female client referred me to Dr. Christiane Northrup (1994), a leading expert on women's health, who talks about how she kept telling herself through medical school to learn the tools of the trade even though she knew physicians practiced them very badly. Physicians may open themselves to holistic ideology, such as the belief that individuals are responsible for their own health, in addition to advocating alternative techniques (Konner 1993:15; Tubesing 1979:21). These physicians would change their practice of medicine to include education and empowerment as we have seen alternative practitioners do. Incorporating information on the connection between the mind and the body into his work, Dr. Herbert Benson says "people are dissatisfied with routine medicine that's strictly drugs and surgery, and here, now, is a way to incorporate value systems that people cherish [into medical practice] without sacrificing science" (as quoted in Baker 1997:20).
Other physicians are drawn to the connection alternative ideology makes between spirituality and medical practice. The professional organization's symposium explored the connections between spirituality and professional practice, or integrating one's "inner" and "outer" practice. This symposium's emphasis that "who they are" is more important than "what they do" might be comforting to some physicians given the frustrations physicians now have with their work due to structural changes such as managed care. One physician wrote in this organization's newsletter that he initially explored alternative medicine for the additional healing tools, but soon understood that it was more than the techniques that could benefit his patients. Understanding how his spiritual practice could benefit his medical practice helped him connect with, and heal, his patients more effectively.

Another physician outside this professional organization is drawn to the spiritual aspects of integrative medicine, especially since Western medicine has forgotten how to "heal" people. Activists like this physician argue that Western medicine focuses on curing at the expense of healing. Dr. Dean Ornish says that "to me 'curing' means only getting back to the way we were before we became diseased. 'Healing' is when we use our pain or illness as a catalyst to begin transforming our lives" (as quoted in Easthope 1993:292). The physician in my study said he likes the "profit potential" of integrative medicine, but knows it is also "the right thing to do" since people need healing.

Physicians that are interested in integrative medicine because of holistic ideology are more likely to give up their power to work with alternative practitioners as equals, because through this ideology they have learned that they cannot help patients on their own. A speaker at one of the professional organization's workshop said that as a physician he doesn't
"have time to learn about" all of these other alternative techniques. If physicians pursue alternative medicine with the ideology intact, then physicians and alternative practitioners could develop integrative models where they have equal power. I will explore this issue in more detail later in this chapter.

The majority of physicians are interested in integrative medicine for monetary interests and patient demand, not ideological reasons. They want to learn ways to maintain clients that are dissatisfied with Western medicine and have threatened to take their business elsewhere. To illustrate, one physician says that people in his profession are "more materialistic," so they become interested in integrative medicine when the "market demands alternative medicine." A member of the professional organization sees some physicians who "are financially driven" to explore integrative medicine. A female client says, "I saw some statistic published recently about people spending more of their discretionary dollars on alternative care than on Western care. Doctors want a piece of that market. It's a highly motivating factor." Professors at The University of California, San Francisco (UCSF) campus have created a task force to develop a program in integrative medicine for their medical students. William Jarvis, director of the National Council Against Health Fraud at the Loma Linda University School of Public Health, thinks UCSF is "getting on the bandwagon. It may be as much public relations and marketing as it is scientific curiosity" (as quoted in Russell 1996:A17).

Members of the professional organization suggested that most physicians are interested in integrative medicine for monetary considerations since they lose some clients to alternative practitioners. To confirm that physicians worry about losing business, a member of this organization says
that physicians quote Dr. Eisenberg's findings a lot. Recall that this was the article published in the *New England Journal of Medicine* that found 34% of individuals had used an "unconventional therapy" in 1990 (Eisenberg et al. 1993:248). This member says, "the public is the driver." So even though physicians have some control over what information the public hears about alternative techniques, "the public is experimenting and getting ideas from different directions." "Some physicians just want to be part of this revolution so they aren't sidelined by it." Another member says, these are the physicians who ask in meetings how to "profit by preventive medicine."

To be fair, some alternative practitioners joined this professional organization with profit in mind. Just as some physicians learn about alternative techniques to keep their clientele, several alternative practitioners joined this group to market health products and services. For example, one alternative practitioner said she joined the organization because she needs clients for her new practice.

The integrative organization seems conflicted about the profit potential of integrative medicine. On the one hand, members openly acknowledge the benefits of forming a network of practitioners. One member says:

> The networking is useful. I will refer people to [members of the group]. You're not going to send a patient to somebody unless you thought they would do some good, [because your] reputation is on the line. The patient's health is on the line. Normally practitioners associate with people in their own specialty [so these cross-disciplinary groups are useful].

Networking obviously provides financial gain for some practitioners. At one meeting, the director said that an upcoming association with another hospital might "open up new markets for people." The organizers are trying to publish a book of practitioners so that members can make referrals to each
other. The organization has also begun to allow advertising in the monthly newsletters and on their web site. In these instances members openly acknowledged their desire to achieve financial gain through their membership with this organization. On the other hand, members are clearly uncomfortable with some aspects of these practices. Both physicians and alternative practitioners from the group displayed books and products at the symposium. Yet, organizers told participants to avoid "soliciting." Rather, organizers wanted members to display books and products for "educational" purposes only. Discussing an upcoming series of television shows on integrative medicine, the director said they need a "solid way to present" this information to avoid looking like an "infomercial." Why are members ambivalent about the profit potential of integrative medicine?

One possible reason is that this financial incentive precludes a cooperative association between physicians and alternative practitioners, because physicians need to practice these techniques themselves to acquire the profit. As the director of the integrative clinic said, you lose holistic ideology if you simply apply alternative techniques in Western medical settings. My respondents have seen physicians enroll in courses to learn naturopathy, acupuncture, hand analysis, homeopathy and nutrition. The length of these training programs, and who teaches them, varies considerably. Some respondents spoke about how physicians could take a weekend-long course on acupuncture and then use this technique on clients. The director of the integrative clinic spoke about how "terrible" and "threatening" it would be for physicians to learn an alternative technique and use it within the structure of Western medicine. He said this practice would be "a concern for anyone in this profession," because physicians could not learn the theory behind these techniques that quickly. Another alternative practitioner says
that physicians can legally practice some of these techniques such as acupuncture, but they cannot “do it well.” This homeopath added that physicians would not let him do a needle biopsy after reading a book.

Activists realize that the ideology distinguishes alternative techniques and alternative practitioners’ expertise. To avoid co-optation of the movement’s contributions activists know they must maintain control of these beliefs.

Some members express frustration that physicians in the professional organization seemed to be more interested in learning the techniques than how to practice them with holistic ideology intact. Physicians can then simply apply these techniques within their Western practices. They will probably benefit financially since they retain clients who are frustrated with Western medicine. Physicians do not need to take time off from work to receive extensive training. They do not need to take extra time during work to use these techniques with holistic principles intact. We have already seen, for example, that enabling clients to take individual responsibility for health requires extensive education. Physicians need a structure that could accommodate the increased time they would spend educating and empowering patients. This would force these physicians to see fewer patients, thus decrease their income. I will address this issue in more detail later, because some activists are contributing to this problem by divorcing the ideology from the techniques in their discourse. This is just one of the possible conflicts that arise as the collective identity of activists changes.

CHANGING COLLECTIVE IDENTITIES AND NEW CONFLICTS

Collective identities are not static, but changeable and contested depending on the specific historical period. Whittier (1995) argues that the concept of collective identity is central to understanding how social
movements change over time. She says that even a few years can make a significant difference in an identity since attitudes, information and the opposition's position change rapidly. Whittier explores how the collective identity of feminist changed as new cohorts entered the women's movement. In particular, she describes the new areas of conflict that emerged between older and newer activists. Feminists debated the role of spirituality and sexuality, for example.

Following Whittier's framework, I outline how activists are beginning to change their collective identity from "alternative" to "integrative." I examine potential conflicts that emerge as activists change their boundaries, political consciousness and strategies. Activists have expanded their definition of "we" to include physicians, yet alternative practitioners and physicians have different levels of power. Integrative activists are critical of the way physicians practice Western medicine, especially their objectification of patients and over reliance on technology; however, activists are less openly critical of Western tools such as drugs and surgery. They have developed a range of personalized political strategies to include educating physicians, businesses, insurance companies and the public. I examine difficulties with maintaining ideological integrity in practice since activists have moderated their discourse to gain access to physicians, companies and mainstream clients. As the movement attempts to become institutionalized, I examine opposition activists still face from physicians.

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5Melucci (1995) also examines conflicts that arise as activists construct and maintain collective identities.
OPENING BOUNDARIES

Activists have reached out to draw physicians into their campaigns, and this has changed their interactions with each other and the public. Rather than staying on the fringe of Western medicine, these activists are trying to "bridge the gap" between Western and alternative medicine. Activists are more concerned with their public image now that physicians are involved. Physicians bring a heightened level of exposure to the movement, so activists are more concerned with professionalism and spirituality. Yet, they also bring a higher status, and more power, which affects interactions among activists.

More physicians are joining the alternative health care movement. I have just shown that physicians might be interested in alternative medicine for financial and/or ideological reasons. A practitioner involved with an integrative practice says, "I just see that there's interest in alternative medicine. For a while it didn't include many physicians, and now that seems to be one of the groups that's leading the way." Several physicians work at the integrative clinic. Physicians established the professional organization, and one acts as the director. The latest figures for this organization's membership show that more than 60 of the 200 current members are physicians. Many advocates of this approach call their work "complimentary" or "integrative," rather than "alternative." A dance therapist says she views her work "as complimentary. Clients would agree with that. A few people wouldn't want to see a physician, but the majority combine modalities."

Due to their credentials and respectability, physicians gain a lot of media attention for integrative medicine and the alternative health care movement. Dr. Andrew Weil and Dr. Deepak Chopra are two of the most
well-known figures. They both advocate combining alternative and Western medicine through several best-selling books, countless magazine articles, television appearances, web sites and medical centers. A wide range of journalists turn to Weil and Chopra's work to lend credibility to their claims. To illustrate, an article in *Good Housekeeping* (1997) included an interview with Dr. Weil, and *TIME* put him on their cover (May 12, 1997). *Newsweek* ran a cover story on Dr. Chopra (October 1997). Media sources also cite other proponents such as Dr. Herbert Benson and Dr. Alice Domar from Harvard, Dr. Mehmet Oz from the Columbia-Presbyterian Medical Center, Dr. Dean Ornish and Dr. Rachel Naomi Remen from the University of California, San Francisco and Dr. Larry Dossey who works in Dallas.

Journalists quote these physicians and their medical institutions by name to bolster their claims about integrative medicine. In her *Good Housekeeping* (1997) article on Dr. Weil, Rubin immediately mentioned that he attended Harvard Medical School (117). Levine (1997) justifies her position that "alternative medicine isn't just for kooks anymore" by referring to "scientific studies" and quoting Dr. Woodson Merrell, an "assistant professor of medicine at Columbia University" (313). Dranov (1996) questions the usefulness of alternative medicine in *Ladies Home Journal*. When she turns to the possible benefits of alternative medicine, though, she quotes Dr. Weil (97). Another article on alternative medicine in *TIME* examined the work of notable physicians such as Dr. Eisenberg and Dr. Ornish (Langone 1996). Barasch (1992), discussing the "mainstreaming of alternative

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6Dr. Deepak Chopra started The Chopra Center for Well Being in La Jolla, California. Physicians offer medical consultations and training in mind body techniques. One two hour session with both a doctor consultation and nurse education costs $300. Practitioners and therapists offer massages and facials from $55 - $210. Guests may also visit the center for three or seven day trips. These healing packages start at $1250, and do not include lodging costs.
medicine,” explains that most patients sent to Dr. Kabat-Zinn’s Stress Reduction Clinic at the University of Massachusetts Medical Center “have been referred by physicians” (9).

The increased number of physicians advocating integrative medicine is one reason that mainstream media sources now cover alternative techniques. These articles used to be the sole property of publications such as the New Age Journal, which declares that mind-body medicine “is widely accepted now” (Spring 1997:9). Articles on integrative medicine now appear in diverse mainstream sources from women’s magazines such as Cosmopolitan and Good Housekeeping to the covers of current affairs magazines such as Newsweek and Life. To illustrate, one article in Life magazine says that the healing power of massage makes it “serious medicine” (August 1997:53). This article goes on to say that massage has gained popularity and respect in recent years (57). Many of these articles refer to the work or opinions of physicians, especially those mentioned above.

It is unrealistic to conclude that all media coverage on alternative medicine is now favorable given the voices of a few select physicians. Many articles continue to warn readers about unscientific practices. For example, one article in the San Francisco Chronicle says “take care not to get burned by alternative treatments” (December 9, 1996:C1, 2, 8). Hall, the author, goes on to warn that individuals or companies with commercial interests provide much of our information on alternative medicine. Writing in the New York Times, Kolata (1996b) argues that studies funded by the Office of Alternative Medicine, part of the National Institutes of Health, have failed to show whether specific techniques work. Kolata notes that critics believe that the very existence of the Office of Alternative Medicine “lends an air of scientific credibility to treatments that most scientists would disavow.” The next day
Kolata (1996a) wrote an article that quoted Gerald Gergasko whose wife died from metastatic breast cancer. Referring to his wife’s use of herbs and megadoses of vitamins, he said that “on her deathbed, she made me promise that I would see to it that nobody else in her family and none of her friends would get involved with this stuff.” Yet, more media sources are covering alternative medicine, especially those praising its benefits.

These sources have an effect on people that are open-minded, but have little knowledge of alternative medicine. Though unstudied in my research, it is likely that these articles are more persuasive when journalists rely on physicians for credibility. In addition to professional expertise, these articles rely on personal testimonies since they often sway potential recruits (Taylor 1996). To critics, these testimonies are merely “anecdotal evidence” (Kolata 1996a). To proponents, these stories are convincing. “Remember people are reading all the publications coming out. They are reading about a lot of alternative things that are going on. There are so many articles on things people have tried.” More directly, these articles provide information on specific clinics since many readers are open to alternative techniques, but do not know where to find practitioners. “Very often people have read [the founder’s book] and they see that there’s a center and so they call.” In addition to advertising, sources such as the New Age Journal (Spring 1997) provide listings of professional associations. Someone could call the American Foundation of Traditional Chinese Medicine in San Francisco, California to find an acupuncturist in their area, for example.

Some activists have become keenly aware of their public image since they have opened their boundaries to physicians, especially given this increased media attention. Activists want to appear credible to these physicians and to be worthy of their participation. However, these activists
also recognize that the movement receives more public exposure given physician involvement. I use two examples, relating to professionalism and spirituality, to show how interactions among activists have changed as physicians enter the movement. Both examples show that activists are more concerned with their public image now that physicians are involved.

First, activists that are working directly with physicians are more concerned with appearing professional. I was struck by how much the professional organization discussed the need for professionalism, and the logistics of attaining this in their symposium. The director talked about how they had created a “Hollywood production” by including such services as a professional meeting planner, videographer and sound technician. They had a strict dress code for speakers that included specific information on how to look your best on camera. The consultant asked each speaker to prepare a one minute sound bite for the video, because the videographer knew that news stations would not take longer segments. During one of the questioning periods after a session, the moderator reminded everyone that both presenters and audience members should keep their comments under thirty seconds or “sound bite length.” One member said:

they were concerned that it came off looking professional, and I think they achieved that. It was not a scientific conference. It was more of a program that was orchestrated. I knew that going in. As long as you don’t masquerade as one thing and do another, [it is okay to do this].

7The interest group was also concerned with their public image, but this was because the organization tried to educate the general public and legislators. As the head of publicity for the health fair they organized, I was made aware of the need for publicity in mainstream news sources, not just the alternative sources, for example.

8In addition to not filling all available spaces, one of the reasons why they lost money on the symposium was because they used so much money “producing” it (newsletter August 1997).
This group had been interested in their public image long before the symposium. They have a public relations committee that focuses "on maintaining our public image." These examples illustrate how members are aware of how they need to portray themselves professionally if they want favorable media coverage. Yet, members' concern for professionalism is also tied to the fact that physicians were involved. One member said:

They [MD's] are taking a risk, and with good justification. It's not just paranoia. They know the power of the state board and what it can do to you, so they are taking risks. They see security in numbers. If they get a movement going that's large, and therefore has political strength, they will be less susceptible to divide and conquer tactics. So they want [the symposium] to look good. The physicians have a lot to lose. They are "board certified." If they lose it, they are out of a job. Whereas, I get the sense that if you are a Reiki practitioner, you can hang out your shingle, and there's no board that will take that away.

Second, activists distinguish their movement through the spiritual elements behind alternative medicine. This has both positive and negative consequences. The emphasis on spirituality is positive since several physicians and popular authors believe we are in the midst of a collective, and growing, quest for spiritual awareness (Dossey 1989, 1996; Gawain 1986; Jampolsky 1970, 1985; Norwood 1994; Williamson 1994; Zukav 1989).

Williamson (1994), one of the popular authors that addresses this cultural change, says, "there is a spiritual renaissance sweeping the world. It is a revolution in the way we think" (3). She suggests "a mass movement is afoot

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9 At an earlier workshop, a physician said that if you are not paranoid enough, you will lose your license as a physician (field notes 4/17/97). He admitted that he had consulted a lawyer about what he could say to cancer patients about nutrition.
in the world today, spiritual in nature and radical in its implications" (xvii). Why are we witnessing this surge in spirituality, and corresponding interest in integrative medicine?

The baby boomers play a role in this cultural shift toward spirituality (Roof 1993). Having been born between approximately 1946 and 1964, they are now approaching mid-life and the corresponding “mid-life crisis” (Goldstein 1990:xii). One of my respondents said that at a point in our lives we need spirituality and usually it is during middle age. This occurs for a variety of reasons. “The pull toward a more spiritual dimension around mid-life is a primordial, persistent human need...it is the need to transcend the newly discovered limits of our own bodies and the limited span of our lifetimes” (Goldstein 1990:275; Roof 1993:248). One physician acknowledges that the baby boomers are a “huge market for integrative services” since their health becomes more important and visible in their lives at this age through its deterioration. “A keen awareness of physical aging is the single most powerful ingredient of mid-life” (Goldstein 1990:136). Since the search for spiritual awareness is a “lifestyle decision,” integrative medicine steps in to provide a framework for how the mind, body and spirit are connected (Williamson 1994:57).

Williamson (1994) suggests that “spiritual concepts are breaking into the vernacular despite the resistance of a materialistic bias”; however, it is precisely our materialistic culture that has fueled this return to spirituality (36). Looking to external, material things such as monetary gain for comfort and fulfillment has proven incomplete so many turn to spirituality for “inner peace” (Gawain 1986:5; Jampolsky 1985:3; Peck 1997:244; Williamson 1994:6, 11). “Throughout the world there is a growing recognition of the need to feel fulfillment within, rather than to rely on the external symbols of
success" (Dr. Jampolsky 1970:12). This recognition is especially strong among baby boomers who are the first generation to do worse financially than their parents, and have found that materialistic values contradict other beliefs they may have held since their participation in 1960s social movements such as racial equality (Goldstein 1990:23-4; Jones 1980:330; Leinberger and Tucker 1991:1-2; Roof 1993:46, 64, 168). Since many individuals are finding spirituality through their experiences with illness, some shed their reliance on material comforts for fulfillment after pursuing spiritual healing. One activist describes how individuals in his support group begin to see illness as a "gift." This particular support group focuses on spiritual healing. He says:

At the support group you hear people say that being HIV positive was a gift for them. After getting over the initial shock and realizing it wasn't a death sentence, suddenly they got to know themselves. They realized that what they were trying to do, the country house and the BMW, had nothing to do with what they wanted. Those were the expectations. That was how they were judged by people. So for many gay men, particularly with HIV, it's really given them a chance to get to know themselves and start enjoying life.

Baby boomers are not simply turning to religious institutions as their parents did; rather, they are creating their own personal blend of religious and spiritual traditions, and being tolerant of the different ways to achieve spiritual awakening. Many authors noting our cultural return to spirituality emphasize that there are different pathways to this level of awareness (Dossey 1996:18; Gawain 1986:7-8; Jampolsky 1985:5; Ring 1980:264; Roof 1993:243-6; Williamson 1994:53; Zukav 1989:15). This religious tolerance

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10Of course, fundamentalist groups often oppose religious tolerance believing that their way to spiritual enlightenment is the only right way (Dossey 1996:19). Religious tolerance is not absolute in the society as a whole, or among baby boomers as a group.
and personal spiritual eclecticism are particularly fervent among baby boomers (Roof 1993:46). Fox has labeled our society a “post-denominational age” where individuals blend various religious and spiritual traditions (as quoted in Williamson 1994:30). These spiritual traditions are not necessarily housed within religious institutions. Religious institutions can provide frameworks, but many seeking spiritual transformation look elsewhere. Many authors and lay people distinguish between religion, which has an institutional connotation and spirituality, which has a more personal connotation (Roof 1993:76-7). Some people who pray and feel deeply spiritual identify as agnostic (Dossey 1996:42). Others use Christian terminology in non-traditional ways, as we saw with the spiritual center associated with the feminist women’s clinic (Jampolsky 1985:4, 9; Williamson 1992:39).

Given these cultural changes, more consumers want their physicians to address spirituality within medicine, and some physicians are beginning to get the message. Most polls show that the majority of individuals in the United States believe in God, including baby boomers (Peck 1997:204; Roof 1993:73). Seventy-five percent of patients believe physicians should address spirituality within their medical practices, and 50% want physicians to pray with them (Dossey 1996:2).11 Some studies show that the majority of women and men pray regularly so they do not necessarily simply turn to religion once ill (Dossey 1996:39). As more consumers implore medicine to explore the connection between mind, body and spirit, physicians themselves have begun to explore these connections (e.g., Dr. Herbert Benson, Dr. Larry Dossey, Dr. Rachel Naomi Remen). One physician in my study is developing an integrative medical model since the spiritual aspect of holistic medicine

11A TIME/CNN poll found that 64% of respondents believe that “doctors should join their patients in prayer if the patients request it” (June 12-13, 1996).
appeals to him. Five medical schools have developed programs examining
the connection between faith and healing, and Harvard Medical School held a
conference on "spirituality and healing in medicine" in December 1995.
Some of these physicians are beginning to realize and admit that science
cannot explain everything they see in their medical practices (Dossey 1989:63-
4; Northrup 1994:12). For example, Dr. Moody (1988) and Dr. Ring (1980)
discuss near-death experiences that typically occur in hospitals where
physicians are present. These experiences change people in many ways, and
they raise spiritual questions that patients increasingly ask physicians to
answer. Other physicians are studying the healing effects of prayer. One
leader in this area of research, Dr. Larry Dossey (1996), is even beginning to
question whether it is malpractice for a physician not to pray for his or her
patients given the overwhelming findings that prayer is medically beneficial
(2, 65, 72). Individual physicians do pray for patients, yet many do not tell
their patients or colleagues about this practice out of fear. Dr. Rafael Campo
(1997) says he feels compelled to pray for patients, but realizes he must do this
secretly. These physicians are in the minority of Western medicine as a
whole. Their experiments are "not exactly mainstream" (Wallis 1996:58).

The experiences of members of the professional organization illustrate
the positive and negative elements of including spirituality within
integrative medicine. Despite the technological progress we have made as a
society, or in part because of it, we feel disconnected as a culture (Gawain
1986:63). Several respondents agree that "we are more disconnected or
isolated." This isolation occurs within medical institutions and outside
them. One way to combat this is through our culture's return to spirituality.
To illustrate, activist organizations create a sense of community through
spiritual practices. During the symposium, the professional organization
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arranged speakers on a variety of topics. At the beginning and end of each session members of the “spirit” group would play or sing songs, read stories or act out skits. After the symposium, one member wrote in the newsletter that he felt he had “made an important connection.” The director said that they have “moved from information gathering to interconnectedness.” Several members suggested that the spirit committee was responsible for creating this sense of community at the symposium.

Not all members are as comfortable with the spiritual aspects of the professional organization. Members formed a healing circle around the director because he was sick during the dress rehearsal for the symposium. One member of the group said that since she is a member of a religious denomination, she could have just as easily been praying for this director. She is “not sure what to make of the spirit group,” even though “it added some warmth and some of the stories were pretty inspiring.” This member thinks she is “the oddball,” but at least one alternative practitioner said that the spirit group may make them lose credibility as a group. These activists are concerned with how physicians and outsiders may perceive the spiritual elements of their collective identity. Though the professional organization “emphasizes whatever one believes” it is obviously difficult for some to appreciate this diversity, especially since members want to look credible in the physicians’ eyes. Even the director acknowledged that as a physician it felt strange to participate in some of the spiritual or communal activities. He was referring to a regular meeting where the organization had speakers play

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12 This organization is sub-divided into different committees. Members may join the biochemical committee, for example, or the spirit committee just mentioned.
drums, lead chants and meditation. At the next meeting the director joked that he thought the hospital would call him to ask what they were doing at the last meeting.

Some physicians may be uncomfortable with the spiritual aspects of integrative medicine since Western medicine is a "relatively secular profession" (Peck 1997:202). Dr. Larry Dossey (1984) says that physicians are no less spiritual than others. They just believe religion and science are incompatible or that religion is unnecessary to science (vii). "Western medicine has spent the past 100 years trying to rid itself of remnants of mysticism," or separating medicine from religion (Wallis 1996:59). One respondent, not involved with the professional organization, said only four physicians came to his talk on "spirituality and health care" even though the "room will be full" when he discusses alternative techniques. Whether physicians believe in the connection between the mind, body and spirit or not, they may be uncomfortable integrating spirituality into their work.

Spirituality is an integral component of alternative medicine. Some respondents even said that the alternative health care movement is moving in the direction of greater spiritual awareness. As activists open their boundaries to physicians, they need to learn how to maintain this element while recognizing that some physicians may be uncomfortable. Most importantly, activists need to avoid stripping their collective identity of spirituality just because physicians have more power.

Another argument is that "fewer than two-thirds of doctors say they believe in God. 'It is very important to many of our patients and not that important to lots of doctors'" (David Larson, a research psychiatrist at the National Institute for Healthcare Research, as quoted in Wallis 1996:64).
An integrative team approach requires that practitioners work side by side with physicians. They must have equal power. Yet, physicians and alternative practitioners have different levels of power in society, and this can militate against a true team approach. At the integrative clinic one of the practitioners mentioned that the “physician here likes to be the physician and wave her title. So I have to be respectful, but not necessarily back down.” Members of the professional group told me that physicians have more power within the organization. One member explains that physicians need to have more power or they will not get involved. The alternative practitioners seemingly concede power since they are “grateful” that physicians are “putting themselves out there” when “they don’t have to,” and giving them credibility.

The MD’s have the most influence in the group. Unless you do it that way, though, you wouldn’t get their participation. They are at the top of the food chain, and you want them involved. That’s what’s different from holistic medicine in the past. There is a psychic and holistic medicine fair each year. Physicians wouldn’t be within one mile of that! If you are a practitioner of Alexander therapy, you can be a part of that one and these other [groups]. There’s not much risk. So I think the alternative practitioners are very grateful the physicians are here, and that they are getting something closer to an equal footing. They are very appreciative the physicians are part of the group, and they try to rise to the occasion.

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14 Power differences between physicians and alternative practitioners are not inevitable. During a presentation within the professional organization a chiropractor thanked the others for the “opportunity to work side by side with an orthopedic surgeon.” He said he usually sees walls between physicians and alternative practitioners like himself. He believes breaking down those barriers is “what the [organization] is all about.”

15 See Kleinman (1996) for a similar discussion of a holistic health center run by baby boomers.
Respondents imply that power differences between physicians and alternative practitioners will persist as long as there are different risks involved with joining an integrative practice. Physicians still have much to lose. The political context is changing, but opposition within Western medicine remains strong. One respondent has found that physicians are not necessarily skeptical of alternative medicine, but "cautious" since they are afraid of "censure and lawsuits." Medical boards can revoke a physician's license for using or recommending alternative techniques. "So I have found that when I talk to physicians they almost feel that they have to be fairly quiet about what they are doing, for fear of censure by their own peers." Physicians will be able to stay in a position of power within integrative practices since they have more to lose, thus more input in how they develop. Alternative practitioners are coming from a position of powerlessness since they are not taking as much of a professional risk.

Differences in power cause some alternative practitioners to use caution when they interact with physicians, especially since physicians are already feeling threatened due to the financial and organizational changes I outlined.\(^\text{16}\) One member of the professional organization said a speaker was too arrogant and "in your face." There is a "time and place" for that approach, but he believes it is better to persuade physicians through "logic and reason" since it is less threatening. The director of this organization said that members should not feel as if "we have to impose the things we know," because "it will happen naturally." He reminded the group to "do this as a family with the power of love," not competition. He said, "don't just put the finger on the doctors. It's you too. We all get defensive, isolated and

\(^{16}\text{A member of the professional organization says that physicians are "threatened by HMO's."} \)
One of the physicians said during his presentation, "don't put down Western medicine. It's useful. It's why we are living longer." The director said we would be foolish to throw out Western medicine. These comments about the strengths of Western medicine show a change in activists' political consciousness.

CHANGING POLITICAL CONSCIOUSNESS

Since physicians are now involved, activists have changed their political consciousness to critique the way physicians practice Western medicine, as opposed to their tools. Activists with a collective identity of alternative and integrative medicine have the same complaints about how physicians practice Western medicine. Activists think a holistic approach is superior since they believe that Western medicine is alienating, impersonal and disempowering. What is different is that integrative activists are more vocal about the need to retain Western tools such as drugs. Numerous activists have seen the value of Western medicine for crisis care throughout their involvement in the movement. Yet, participants are willing to discuss this more openly now that it is no longer a question of alternative or Western medicine, but how to use both. For example, a YOGA teacher says "that's not to say there is not a time for the scalpel, antibiotics or an anti-inflammatory. There certainly is, of course. Everything has a time and place." An acupuncturist adds that he "would never omit all of the Western technological help that's available."

17 Later, he uses the example of a practitioner of Oriental medicine that was so emphatic about nutrition that he kept trying to use this one approach even when it may not work. He said, alternative practitioners "can be that way too" (field notes 4/10/97).
Activists emphasize the utility of Western medicine for crisis care. Clients said they would see a physician if they were in "a car accident," or "hit by a truck." One client says, "don't get me wrong - there's a place for crisis care, like with broken bones." A hypnotherapist says that when clients come in:

we always recommend that they see a physician, because there are things, like setting a broken bone, that doctors do and we don't... I have nothing against conventional medicine. I know that in some cases it hasn't worked well for me, and some it has. So when I get something, which I don't very often, I go see the doctor. I go for check-ups and all those things you are supposed to do. It's just that I would like to see a little bit more choice for a client.

Activists also believe Western drugs are useful for certain infections. "Western medicine has its strengths. As my acupuncturist has reminded me, don't come to me if you have pneumonia. There is nothing I can do for you." A male client says that "sometimes a physician is important to give a shot or pills to fight infection." A female client said she saw a physician "to make sure I wasn't being foolish and ignoring a symptom that should be treated by Western medicine. There are times when I feel like attack is the best solution and go for the drugs." Many of these activists do not discount Western medicine, because "we take our miracles where we can get them," as one woman put it.

Activists are willing to open the movement to physicians because they are noticing changes in physicians' attitudes toward alternative medicine. A Rolfer says she "noticed a change in physician's reactions. They have heard of Dr. Bernie Siegel.¹⁸ There is more popular awareness that alternative

¹⁸Dr. Bernie Siegel is the author of Love, Medicine & Miracles. I mentioned his ideas in chapter three.
medicine can work in some cases, and that nothing works universally.” Other activists had stopped using Western medicine, and are now seeing physicians again. A massage therapist says she has been “moving back into including Western medicine, because it seems a little more open than it was.”

In particular, activists see vast changes in the medical training physicians receive. A hand analyst says that:

> medical schools are starting to offer strong options for nutrition, acupuncture and homeopathy. It's not enough yet, and it's still offered on an elective basis as far as my understanding goes, but I think that's where the changes are going to occur. [Medical schools] already are shifting so radically.

A client adds:

> I have seen much greater acceptance within the Western medical community. There will be some level of openness as more doctors in training hit the streets. They were weaned on the idea that the Western scientific method gives us good medicine, but has its own biases and limitations. I know someone going to medical school and he'll be open. He may be concerned with the amount of money being spent by the client, but not since he wants it. He won't be inherently threatened. He won't be trained in the “I am God” series...I think that's something I see among friends.

Activists maintain that physicians need to use Western techniques within the framework of holistic ideology. Effie Poy Yew Chow (with McGee 1994) says she "considered the positives and negatives of both Western medicine and Traditional Chinese Medicine. I decided to take the best of both approaches and blend them together to form a better system in terms of both cost and effectiveness” (30-32). She has “a very high regard for Western medicine, but strongly believes that the impersonal high technology of modern Western medicine [should be] combined with ancient Eastern
concepts and practices.” Activists need to educate physicians to ensure that they use Western techniques within the context of holistic beliefs and practices. This is one of the new strategies that activists must use to prevent physicians from co-opting their techniques.

EXPANDING STRATEGIES

The collective identity of integrative medicine retains the same personalized political strategies integral to the collective identity of alternative medicine. Activists continue to deliver services and transform the workplace, for example. Yet, activists have expanded their strategies to include seeking support from businesses, insurance companies and physicians. Jenson (1995) argues that social movements seek recognition of their collective identity by institutions. However, I find that activists make certain concessions to achieve this recognition. Activists in the integrative clinic emphasize results and cost-savings with businesses and insurance companies, rather than holistic ideology. Members of the professional organization explain alternative techniques to physicians without necessarily referring to these beliefs. It may be difficult for activists to maintain ideological integrity since both practices divorce alternative techniques from the beliefs that make them effective. By doing this, activists risk losing control of the beliefs that are fundamental to their collective identity.

Gaining access to established institutions while maintaining the integrity of their identity and goals is a double-edged sword for movements. On the one hand, many activists are willing to moderate their discourse to influence mainstream institutions. Hunt, Benford and Snow (1994) explain that when movements interact with these institutions, activists try to “talk
their language." Activists may examine "audience" identities\(^1\) to determine how to obtain their support. For example, a member of Nebraskans for Peace says that their organization realizes that elected officials face financial constraints so activists emphasize the financial "bottom line" when they discuss movement issues with these politicians (200). On the other hand, these movements still challenge existing institutions. English-Lueck (1990) says that the alternative health care movement must find a way to legitimize their practices with established authority while rebelling against it (64).

The integrative clinic is developing a program to encourage insurance companies and businesses to use their services. Similar to the activists Hunt and his co-authors mention, practitioners emphasize results and cost-savings with these companies. Though this is a sound strategy there are some potential problems. Activists discuss cost-savings and results at the expense of holistic beliefs. These beliefs are an integral component of their collective identity. Activists risk losing control of these beliefs even though practitioners insist that they are not willing to compromise these ideological principles in their practices. It is important to give some background information on this program.

The integrative clinic identified two barriers to using alternative techniques or integrative medicine. First, some individuals do not know the option exists, so clinic practitioners provide community lectures and group classes in order to educate the public. Yet, the small numbers of people who attend are already familiar with alternative or integrative medicine. Second, the more difficult barrier is that some individuals are unable to pay for this care. The directors decided to develop a program encouraging insurance

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\(^{1}\)Hunt et al. (1994) argue that we have to examine the collective identity of the "antagonist" and "audience," not just the "protagonists," since identities are social constructions (192).
companies and businesses to use their clinic since most individuals get their health care paid by insurance, usually provided by employers. The directors would speak to insurance companies and businesses rather than employees because they have the "final say" about health coverage.\(^\text{20}\)

The director of the integrative clinic says that there are two principle requirements for success: one, delivering results and articulating their ideas in a way that cynical business people will believe; and two, operating in a way that reflects but does not compromise their holistic approach. To achieve the first requirement for success practitioners have focused on their discourse since the clinic is confident they can deliver results. Most of their fliers say they provide "effective, efficient and affordable" care. By emphasizing results and cost-savings, this clinic is trying to work within the existing cultural framework and speak the language of businesses. They do not discuss their ideology, because they do not want employers or clients to think that they need to believe in holistic principles to get results.\(^\text{21}\) The director said he would approach companies by saying "forget all of the philosophy. We can help your employees stay healthier..." He continues:

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\text{I'm very careful about talking about this in general. When I speak in public it's more about building bridges with the mainstream, [and] trying to be very, very inoffensive without compromising [the] basic principles. We are not going to talk about the female force, the life}\]

\(^{20}\)Though practitioners are working within the existing reimbursement system, they want to develop a model that can be used once the existing medical and insurance system collapses. Members believe these industries are "on their deathbed," and they want to encourage and quicken this change. "Mainstream medicine is making us sicker." This is "not philosophy, but statistics," says their director.

\(^{21}\)One practitioner says that she would like to share more of these beliefs with clients, because it could help them. With the majority of clients, however, she doesn't "feel it's appropriate, because they will get turned off or feel uncomfortable."
force and even spirituality. It’s great because it works. So, if you want results, just try it. Now how it gets the results, I think eventually you can’t avoid the issue.

In initial conversations, practitioners can avoid discussing the actual alternative techniques with companies by saying they simply promise results. When providing more detail on their program, they eventually need to discuss the different types of medicine practitioners within their clinic use. So practitioners begin with “conventional medicine” since “it’s where most are standing now.” It “opens the door to rest of the system.” Possibly contradicting their insistence that the team of practitioners are equal players, one of the drafts of a flyer says that the physician makes the initial diagnosis, “prescribes the optimal treatment plan,” and “oversees the program.” “Individual practitioners consult with the physician monthly for team progress reports.” Since practitioners are still developing these team conferences it remains to be seen whether they are simply saying that the physician is in charge to reassure companies and employees, or if this is actually the way it will function.

These activists know that they cannot sacrifice using ideology in their practice of medicine since the beliefs behind the collective identity are the key factor that sets their vision of medicine apart from Western medicine. The director says existing models have made these compromises. For example, he believes Dr. Andrew Weil simply lays out a "smorgasbord" of techniques divorced from their ideology. So to maintain this integrity, the clinic needs to remain small so that practitioners can get to know each other and the client personally. The director of the integrative clinic stresses that the practitioners do not want to treat all of the members of a business or insurance company since some will not take individual responsibility for their health. Yet, the
integrative clinic may see more of these “allopathic” clients if they do not discuss the ideology behind integrative medicine with the clients’ insurance companies or businesses.

Members of the professional organization are educating physicians about alternative medicine, but they also face problems keeping the techniques connected with the beliefs. One of the members said material in their presentations is not new, but to the 20% who are physicians, it is all new information. Some members expressed frustration that physicians in the professional organization seem more interested in learning the techniques than practicing them with holistic ideology intact. To illustrate, physicians often want practitioners to explain alternative techniques in Western terms since they have Western scientific training. A physician said that she needs enough information during the presentations at the symposium that she would ask for more. She said, you “have to speak to me, or I won’t speak to my patients.” Her whole point was that she needed the speakers to use scientific terms, and put their work into the context of Western medicine.

One member of the professional organization in particular spoke about her frustration that symposium organizers wanted speakers to explain their specific alternative technique in a twenty or thirty minute presentation. Rather than explaining a technique in the context of how to use it, this type of presentation educates physicians about alternative techniques, not ideology. Alternative practitioners do not criticize this practice with other members of

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22Alternative practitioners also learn from these presentations. One alternative practitioner said, “it’s not new to me, but there are nuances to everything. When you are a specialist you don’t see the whole perspective.”

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the professional organization even though they shared their frustration with me. Many are simply willing to concede power since they want physicians involved.

Maintaining holistic beliefs is critical since without it, physicians may think alternative medicine is only a set of techniques, not a way to practice medicine. With the beliefs and collective identity, alternative medicine becomes much more. Most importantly, an understanding of the collective identity should prohibit physicians from simply co-opting alternative techniques for their practices within Western medicine. To prevent co-optation of techniques, activists teach physicians that clients require multiple practitioners to heal, and hope that physicians will learn there is too much for one practitioner to learn, even a physician. Yet, by moderating their discourse to gain access they are risking the one element of their collective identity they can least afford to lose.

The movement is gaining access to institutions, and activists are seizing these opportunities in the short-run; however, activists need to think about how their choices will affect the movement long-term. Externally, activists may find that they lose control over the techniques and beliefs that they have worked so hard to develop. One acupuncturist said activists would be confined to a "bitter role" if they "aren't part of it" when Western and alternative medicine merge. Physicians and insurance companies would "get all the glory and control" even though activists have done all the work. Internally, "the politics of simultaneous insider and outsider activism" can divide a social movement (Epstein 1996:287). Spalter-Roth and Schreiber (1995) find that feminist groups such as the American Association of

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23Epstein (1996) examines these "contradictory impulses" in the AIDS movement.
University Women generate criticism, especially from within the movement, because they often make compromises to establish or maintain insider status. "They were accused of being simultaneously too insider and too radical" (106). Even though their insider tactics did not make their goals more conservative, they did lead to organizational tensions (114). Tension between outsider and insider status forced these organizations to continually decide between the need for "credibility, funds, and organizational unity, on the one hand, and accountability to feminist ideals, consciousness-raising, and empowerment of women, on the other" (125).

CONCLUSION

Recent social movement literature examines the relationship between the political opportunity structure and collective identities (Gamson 1995; Snow and Benford 1992; Taylor 1989, 1996; Taylor and Whittier 1995; Whittier 1995). Previous studies have examined how collective identities change as the political climate becomes more hostile (Taylor 1989; Whittier 1995). My study adds to this literature by showing how collective identities also change as the political opportunity structure becomes more favorable to a movement, or in this case, a specific model of medicine.

It is important to understand why physicians have an interest in integrative medicine. The increased complexity and scale of the medical field have led to new financial arrangements and potential. Medicine has been transformed into a health care industry where profit, efficiency, financial managers and consumers take center stage. Even though this entails a gradual erosion of autonomy, physicians are more compliant now and less able to resist these changes. One physician even suggested that all physicians are "outsiders" now given changes in medical reimbursement. Given the
resulting dissatisfaction, more physicians are turning to integrative medicine for a solution. Physicians have financial and/or ideological reasons to join the movement. As I will show in the next chapter, these differing motivations affect how Western medicine responds to the movement at the organizational level.

Physicians remain powerful despite their loss of autonomy and authority. As the movement attempts to institutionalize, the opposition is tightening their restrictions on alternative medicine because activists are threatening the professional livelihood of physicians more directly. When alternative medicine remained an alternative model outside Western medicine, focused on changing individuals, it was less threatening to physicians (Zald and Garner 1987). Physicians take this threat more seriously now that the movement has made inroads into both the institution of Western medicine and the consumers that physicians depend upon. To restrict the alternative health care movement, physicians can rely on the group solidarity and social positions that gave them their power historically (Starr 1982). They still have greater access to reimbursement through their relationships with insurance and the government, as well as political control over licensing. Physicians can also depend on their strong medical associations. One acupuncturist says the California Medical Association is “quite threatened” by a professional association of acupuncturists, and tries “to restrict us.” Activists realize that the “political reality” is that the movement needs to “work off their agenda” or react defensively rather than offensively.

Power differences between physicians and alternative practitioners affect the development of integrative medicine as activists open their boundaries to physicians. One of the most serious problems is when
physicians simply want activists to explain alternative techniques within the framework of Western medicine. Activists often comply since the movement wants physicians involved. The movement also risks separating the techniques from holistic beliefs since they focus on cost-savings and results with insurance companies, for example, rather than beliefs. These beliefs are the key factor that sets their vision of medicine apart from Western medicine. Activists know that they cannot sacrifice using ideology in their practice of medicine. Maintaining these beliefs is critical since without it, physicians may think alternative medicine is only a set of techniques. For true integration of Western and alternative medicine "you can’t take so called alternative tools and scab them on to the existing system. It won’t function, because the whole operative principles are different." Integrative medicine "takes in a whole world view." "If you're not really applying holistic principles, you're not using these [techniques] to their full potential, and you're not doing your best for the patient." "You won’t get the same results and you will get dissatisfied patients," says another acupuncturist.

Interestingly, activists require physicians to use their tools without the accompanying Western ideology, yet alternative practitioners must not do the same. An understanding of holistic beliefs should tie physicians to alternative practitioners since they would learn that addressing the whole patient requires multiple practitioners. Activists hope that physicians will learn there is too much for one practitioner to learn, even a physician. By separating their techniques from holistic beliefs, they are in effect gambling with the one element of their collective identity they can least afford to lose.

Activists want to maintain good standing with physicians since they see society headed towards integrative medicine. However, they also want to position themselves so that physicians cannot simply co-opt their techniques,
personnel and ideology. Though the collective identity of integrative activists differs from that of alternative activists, the core principles remain the same. The movement must remember that the strength and persistence of these beliefs, along with strong bonds between activists, can make co-optation more difficult. For a true integrative model of medicine, activists need to maintain control of alternative techniques, make sure not to divorce these techniques from holistic beliefs, and learn how to equalize the power differential between them and physicians. If they can do this, “the integration of alternative and traditional Western medicine [will be] the medicine of the future” (Dr. Woodson Merrell as quoted in Cosmopolitan September 1997:313). I explore existing and future outcomes, especially co-optation, in the next chapter.
CHAPTER 6

CONCLUSION

The question is no longer "whether or not" alternative or integrative medicine will continue as a medical alternative, but "how will it develop." The alternative health care movement has experienced a dramatic rise in visibility and legitimacy. More consumers are using and practicing alternative techniques, and becoming connected to a movement in the process. As they empower themselves and make the necessary personal changes, they influence their friends and family. Activists also influence the society at large by educating the public, lobbying financial and governmental agencies, and spending enormous amounts of their own money on these techniques. These personal and political actions have collectively caught the attention of insurers, physicians, governmental agencies and the media (Biondo 1997:8). As these groups take a serious look at alternative medicine some see the value in alternative techniques and ideology, and give the movement legitimacy through their approval. As insiders within these groups share their approval, they persuade many opponents to take a look. We need to examine alternative health care as a social movement, because it is this collective effort that has led to these recent changes.

The political changes affecting Western medicine have led to a newer trend toward integrative medicine. Activists are including physicians within the movement, changing their political consciousness and influencing
institutions not just individuals. Changes in activists' collective identity and strategies reflect their increased bargaining power. Since they are still developing this model, we do not know whether they will be able to maintain this position, and control how alternative medicine becomes merged with Western medicine. Some participants show political acuity while others, in the words of one respondent, are "not at all prepared for politics." In this study I have examined the alternative health care movement in the San Francisco, California Bay area in order to understand why the movement has been so successful, and whether participants will continue to control the ideology and techniques they have worked so hard to legitimize. Understanding the explosion of interest in alternative medicine and the newer development toward integrative medicine is a question of how social movements interact with their opposition and the political opportunity structure. Until now I have primarily focused on these interactions from the perspective of the social movement. Here I turn to the opposition's responses to the movement.

I have used a synthesis of resource mobilization and new social movement theories to understand the alternative health care movement. Historically resource mobilization theorists concentrated on political or structural factors while new social movement theorists examined cultural factors. Since movements such as alternative health care engage both politics and culture, theorists are now beginning to examine both types of factors through a synthesis of social movement perspectives (Johnston and Klandermans 1995; Kriesi et al. 1992; McAdam 1994; Taylor and Whittier 1992, 1995). I argue that some alternative health care activists and their organizations do influence and engage political institutions. For example, I observed an interest group that attempts to change laws to ensure access to
alternative health care techniques. Other organizations and participants attempt to create personal changes in everyday life outside institutions, such as those involving lifestyle. I argue that these informal strategies also have political consequences (Lichterman 1995; Taylor and Raeburn 1995). Social movements that focus on cultural elements such as the creation of alternative institutions do not necessarily lack legal and political aims (Taylor 1996). I use both theories to understand the movement's participants, ideology, identities, organizations, strategies, tactics and now outcomes.

Participants

Many activists have been involved in other social movements, such as women's, peace and environmental movements; however, their participation within the alternative health care movement is often more significant to them because they improve their health and quality of life. One woman says her activism "involves my career but it also involves the necessity. I would probably be dead several times over if I weren't so involved in [alternative] health care." Another client says that a friend of his survived AIDS for an extended time due to alternative medicine and his activism. Given the dramatic nature of the changes that can result from using alternative medicine and belonging to a social movement community, these activists want to share their experiences with others.

I find that my participants' involvement in alternative medicine is an extension of their prior activism following a line of research that suggests activists do not leave behind their social movement commitments as they age or as the political context changes (Taylor 1989; Whittier 1995). Participants compare their current and prior activism due to these lengthy social movement careers. Their current personalized forms of activism
contrast sharply with protests and boycotts they may have joined in the past. Roof (1993) suggests that since baby boomers were active in the 1960s in these ways, they do not always see their individual quests as activism (66). Quite the contrary, many of my respondents turn their personal quest for health into activism. They focus on empowering and healing themselves so that later they can do the same for others. This is why one homeopath says she is "an activator of individuals."

I showed how we can conceptualize these seemingly individualized acts as collective action since so much activism within the alternative health care movement takes place at the individual level (Echols 1989; Epstein 1988; Lichterman 1995; Taylor 1996; Taylor and Raeburn 1995; Taylor and Rupp 1993; Taylor and Whittier 1992; Whittier 1995). I used Schneirov and Geczik's (1996) description of the changes that a person goes through upon adopting alternative medicine to show that personal changes lead to "a connection with others and with larger issues" (640). Activists develop a collective identity, or shared definitions and experiences that produce solidarity among a group of people. These individualized actions also have political consequences for the movement. As they talk to friends, family, participants recruit sympathizers and activists for the movement. It is likely that activists will translate personal changes into other types of activism given the significance of the experiences they have with alternative medicine.

**Ideology and Organizations**

Formal social movement organizations do not unite the alternative health care movement since so much activism takes place at the individual level. Instead, activists rely on movement ideology to provide this solidarity. English-Lueck (1990) suggests that ad hoc leaders and cultural heroes replace
strong professional organizations (61). She suggests that organizational commitments give way to symbols and networking. New social movement theorists such as Melucci (1989) emphasize that much collective action takes place in submerged networks, rather than formal organizations. This is true with the alternative health care movement despite the fact that formal organizations do exist.

Ideology is the thread that unites these diverse social movement organizations, and enables activists to recruit other participants (Dalton et al. 1990; Fantasia 1988; Hunt et al. 1994; Melucci 1995; Snow and Benford 1992; Taylor and Whittier 1995). Activists define health as well-being rather than the absence of disease, stress individual responsibility for health, advocate health education, and use "natural" therapeutic techniques (Kopelman and Moskop 1981). Ideology drives activists and almost every aspect of their clinics and organizations. The exception is how much they discuss this with clients or outsiders. In settings where activists want to build bridges with Western medicine or attract "mainstream" clients, activists emphasize results more than ideology. The integrative clinic, for example, tries to be "inoffensive without compromising basic principles." Yet, these principles separate alternative and integrative models from Western medicine, and should prevent co-optation by institutionalized medicine.

The alternative health care movement contains a variety of organizational forms. Mattson (1982) identifies educational, clinical, combination, church-based healing, retreats and programs (95-104). Through interviews and observations I have information regarding all of these types except retreats. Mattson provides a good starting point, but I provide further specification. First, I argue that it is important to distinguish among clinics. I observed a feminist clinic, a solo practitioner that shares office space with
other alternative practitioners and an integrative clinic that combines Western and alternative medicine. These clinics vary depending on whether they identify as alternative or integrative. I show how collective identity influences organizational structure, services, financial considerations, interactions and discourse. Second, I distinguish between clinical settings that create submerged networks, and professional or political organizations that form interest groups (Schneirov and Geczik 1996:631).

Although multiple organizations can weaken a social movement if they compete for resources, I argue that organizational variety strengthens the alternative health care movement since activists can pursue different strategies and provide different resources (Buechler and Cylke 1997:321; Rupp and Taylor 1987; Shapiro 1985:106; Staggenborg 1989; Taylor and Whittier 1993; Zald and Ash 1966; Zimmerman 1987:462). The clinic practitioners are introducing individuals to alternative health care ideology, raising consciousness and sustaining personalized forms of activism in these submerged networks. Clinics act as decentralized social movement organizations that tend to have fewer tangible resources, but sustain high levels of time and commitment (Freeman 1979). They create highly involved activists that benefit the movement through their intensive commitment to alternative practices and cultural change. The interest group and professional organization mobilize tangible resources that activists try to translate into political pressure. They can generate money through membership dues to lobby for political changes and educate broader communities. Having diverse organizations allows activists to determine the type and amount of participation they desire within a movement.
Collective Identities and Strategies

Collective identities and strategies are not static since they reflect a social movement's interactions with the political opportunity structure and its opposition (Gamson 1990/1975; McAdam 1983; Morris 1984; Tarrow 1993; Taylor 1989; Whittier 1995). Activists have been able to change strategies from advocating an alternative medical model to developing an integrative model that incorporates both Western and alternative medicine given recent political and cultural changes.1 Ideologically, practitioners see the patient as a whole person that needs physical, emotional or spiritual healing; whereas, therapeutically, practitioners use a combination of Western and alternative treatment modalities. In practice, an integrative clinic may include an acupuncturist, chiropractor, body worker, counselor and physician. Activists have changed their strategies and collective identity over time as the political opportunity structure has weakened the opponent and strengthened their position.

Physicians are losing much of their professional authority as the medical environment is becoming increasingly complex (Gray 1986:172; Mick 1990:xiii). Power has moved away from the physicians to the medical schools, [1]

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1 Activists find that physicians and consumers are also receptive to integrative medicine due to cultural shifts. These include an ambivalence toward technology and an increased emphasis on spirituality (Dossey 1989, 1996; Gawain 1986; Jampolsky 1970; Norwood 1994; Williamson 1994; Zukav 1989). Baby boomers, due to their sheer size, have influenced cultural trends since their involvement with the social movements of the 1960s and 1970s (Goldstein 1990:34; Kleinfelder 1993; Phillips 1984; Roof 1993). They are now reaching mid-life and are trying to reconcile aging bodies, impending mortality and economic insecurity with their sixties’ beliefs and independence. One respondent says, “the baby boomers aren’t accepting the inevitability of their bodies falling apart at fifty as earlier generations did.” These cultural shifts make integrative medicine more desirable, because this model examines the relationship between spirituality and well-being. This model does not abandon medical technology or Western techniques, but relegates them to a lesser role. Integrative medicine also allows baby boomers to take responsibility for their health as they age through self-care practices. They can take an active role in their health care, rather than a passive role that the technology-driven Western medicine advocates.
hospitals, health insurance companies, health care chains, financing and regulatory agencies (Starr 1982:8, 421). Medicine has moved to a market orientation where profit, efficiency, financial managers and consumers take center stage (Shortell et al. 1990). Physicians are less able to resist these changes despite the loss of professional autonomy they entail. Most importantly, there is an increased supply of physicians, so individual doctors lose their bargaining power (Gray 1986:172, 174; Mick 1990:5-6; Scott 1993:279-80). Physicians are also more compliant due to the hospital's ability to hire and fire physicians, and the reduction of hospitals in which to practice. In addition to the lack of job security, physicians need to deal with the personal challenges of increased loans from medical education, and increased costs due to fear and prevention of malpractice, that force physicians to look for job security in hospitals and HMOs as opposed to private practice. Given the resulting dissatisfaction from their loss of authority, more physicians are demanding changes and turning to integrative medicine for a solution.

Activists include physicians within an integrative medical model. A practitioner involved with an integrative practice says, "I just see that there's interest in alternative medicine. For a while it didn't include many physicians, and now that seems to be one of the groups that's leading the way." Physicians are interested in integrative medicine for financial and/or ideological reasons. Their motivations influence how they will interact with alternative activists to develop integrative medicine. Physicians driven by monetary interests are interested in the techniques, possibly the ideology, but

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2More than 6,000 physicians and nurses nationwide have signed an open letter "calling for an end to for-profit health care" that overrides "compassion and care" (San Francisco Chronicle December 3, 1997:A4).
not the practitioners; whereas, physicians that have been persuaded by holistic ideology will most likely seek equal partnerships with alternative practitioners.

Power differences will persist as long as physicians and alternative practitioners face different risks with joining an integrative practice. Physicians still have much to lose. The cultural and political contexts are changing, but opposition within Western medicine remains strong. One respondent has found that physicians are not necessarily skeptical of alternative medicine, but "cautious" since they are afraid of "censure and lawsuits." Medical boards can revoke a physician's license for using or recommending alternative techniques. "So I have found that when I talk to physicians they almost feel that they have to be fairly quiet about what they are doing, for fear of censure by their own peers." Physicians will be able to stay in a position of power within integrative practices since they have more to lose, thus more say in how they develop. Some alternative practitioners concede this power since they are grateful that physicians are taking such a risk. Alternative practitioners are coming from a position of powerlessness since they are not risking as much. When you start from a disadvantaged position, you have little to lose, but often less control. Integrative medicine requires a team approach to health care where practitioners all have equal power in recommending treatment possibilities. For this reason, activists will need to address the existing power differences between physicians and alternative practitioners.

I have found that the alternative health care movement does not suffer because it consists of diverse activists with varying motivations. In fact, this diversity can strengthen a movement if it translates into a larger activist population. The rapid interest in alternative medicine is due partly to
this wide base of support (Mattson 1982:76). Even before activists proposed working with physicians, the alternative health care movement contained diverse groups. Schneirov and Geczik (1996) show that the conservative Christian right and culturally progressive left worked for the same cause in the Pittsburgh area. They shared similar ideologies and goals even though they did not belong to the same organizations. These authors argue that alternative health is one of a few places where diverse “communities interact and share common allegiances and values” (635).^3

Yet, this diversity within the alternative health care movement can become a problem if these activists make concessions that threaten the movement’s integrity to get the support of these outside groups. Alternative health care activists have decided to moderate their discourse to gain access to Western medicine. The integrative clinic emphasizes results and cost-savings since they try to work within the existing cultural framework and speak the language of insurance companies and businesses. Practitioners do not discuss movement ideology, because they do not want employers or members to think that they need to believe in this ideology to get results. Since these beliefs have held this movement together, and since it is the key factor that sets their vision of medicine apart from Western medicine, these activists also know that they cannot sacrifice using ideology in their practice.

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^3Fundamentalist Christians and counterculture individualists also join forces in the home schooling movement. Some parents home school to provide their children more religion, while others have no religious motivations (Gorder 1990:11-12; Guterson 1992:6; Hegener 1988:22; Whitehead and Crow 1993:116-6, 131). Despite their different motivations, they have all decided to take their children out of the public and private school systems (Guterson 1992:5). The problem comes when one group has more visibility or power than the others, as is the case with fundamentalist Christians in the home schooling movement (Guterson 1992:7). Outsiders see the movement narrowly through the dominant group’s position, and may be hesitant to join or be sympathetic. The movement itself may also become factionalized weakening its political power, preventing a unified front and lessening its chances of success (Gamson 1990; Mayberry et al. 1995:10, 25-6). This is not an inevitable conclusion, however. How the movement deals with these factions is critical since they can either strengthen or weaken their position.

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of medicine. Yet, by moderating their discourse to gain access to institutionalized medicine they still risk losing the most critical component of their collective identity. By losing the ideology, they also risk co-optation of their techniques.

Outcomes

Activists try to create social change; therefore, one important factor to examine is movement outcomes, or the successes and failures of the movement. The success of the alternative health care movement is dependent on the relative power of its intended target, Western medicine in this case, the extent of social networks, nature and extent of claims, media involvement and the availability of resources such as organizing skills (Cable and Benson 1993:473; Wolpe 1990:922). Since activists and observers often define success and failure differently theorists have problems measuring the outcomes of a movement.

Social movement theorists have identified general types of success. Gamson (1975/1990) examines acceptance and new advantages. Gamson defines movement success as gaining acceptance as a legitimate spokesperson for a set of interests, and acquiring new advantages for the group’s beneficiary. Acceptance could imply that those in power consult with this group on a continual basis (32). There are four possible outcomes for a social movement: full response which entails both new advantages and acceptance; co-optation where they do not receive new advantages, but full acceptance; preemption when they gain many new advantages, but no acceptance; and collapse which involves neither advantages nor acceptance. Other social movement
theorists broaden their definition of success to include changes in culture and movement participants, not just public policy (Melucci 1989; Meyer & Whittier 1994; Staggenborg 1995).

Other authors have suggested specific outcomes for the alternative health care movement. Prior literature has examined the relationship of alternative health care to the state. Authors have also examined the levels of insurance reimbursement, media exposure, diffusion of ideology and the number of individuals using alternative techniques. To these I add the level of backlash and national activism. I conclude with an examination of possible outcomes for integrative medicine more specifically.

One way that we can examine the outcomes of the alternative health care movement is to examine its relationship with the state. Though professionals try to control key aspects of the profession such as ethics and training, the state often has the power to license these professionals (Frohock 1992:63). The government can certainly impede the development of alternative health care through licensing (Mattson 1982:151). Yet, activists also want more stringent licensing requirements to protect their practices and credibility. Consumers have a hard time differentiating legitimate practitioners from "quacks" or "charlatans" simply seeking a profit if there is no regulating system (Easthope 1993:290, 294). The alternative health care movement has had limited success since the state only regulates some techniques. For example, the state of California licenses and regulates acupuncturists (Taylor 1979:44). The movement's relationship with the state will certainly change as physicians become more involved, though.

Second, the level of insurance reimbursement is another measure of success. Jan Goodwin, writing in the New Age Journal (Spring 1997), suggests that there is a revolution underfoot in health insurance as alternative
therapies become more mainstream. Health insurers have begun to cover a variety of alternative therapies, especially since 1993 when Dr. Eisenberg and his co-authors published their study on its widespread use. Refer to Table 4.1 at the end of chapter four for a list of these insurance companies and what techniques they cover. A study conducted in 1995 found that 86% of the nation’s largest HMOs covered some alternative therapies. Goodwin (1997) argues that these changes occurred due to market demand.4 “You, the consumer, have the last word...Clearly, this is a case where individuals can help make a difference” (69). Despite the increased coverage, insurance companies still limit the types of techniques and practitioners they will cover. Some insurers only pay for acupuncture and other alternative techniques if prescribed by a physician, for example (Barasch 1992:36; Biondo 1997:8). Yet, activists within integrative clinics may gain more access to insurance companies through their inclusion of physicians. This measure shows that the alternative health care movement has had limited, but increasing, success.

Third, media exposure is an important indicator of success, because this helps a social movement develop public interest in their issue or goals (Smith 1992:142; Taylor 1996). National programs such as Turning Point and Good Morning America have examined the usefulness of alternative techniques and practices. Since these shows have to appeal to a national audience, when producers choose to debate alternative medicine, they are reflecting widespread interest in this issue. This debate “reflects a high degree of cultural uncertainty about medicine’s boundaries and responsibilities to society” (Kaufman 1993:315). Activists have been able to present their

4Some states are mandating that these companies cover these techniques, but they only have power over plans regulated by the state.
alternative model, because of this cultural uncertainty. The movement has certainly been successful in creating this media exposure even though the coverage is not always favorable. Future researchers need to examine what type of impact this exposure has on the public, especially if the coverage is unfavorable.\(^5\)

Fourth, the diffusion of alternative health care ideology is a type of success that is difficult to measure. Our society has seen a shift toward a more holistic model that many argue is irreversible since it has fundamentally altered the way we view health and illness (Carlson in Hastings 1981 as quoted in Alster 1989:2; Lowenberg 1989:2, 91-2). The movement has created a population of educated, well-informed clients concerned with their personal health (Alster 1989:74; Rosch and Kearney 1985:1405). The popularity of alternative medicine has forced some Western physicians to recognize the validity of these techniques and ideology, and change their approach to medicine (Starr 1982:100). The movement has also influenced public health, nursing, dentistry, psychology and behavioral medicine (Lowenberg 1989:78-85). Medical practitioners are stressing prevention and lifestyle issues. They have also adopted some of the terminology and practices of alternative medicine such as "health promotion" and "nutrition" (Wolpe 1990:916).

\(^{5}\)Smith (1992) argues that the media in the United States may provide more favorable coverage on alternative medicine, because we value medical entrepreneurs and fear government interference in our health care choices. He examined coverage surrounding the controversy over whether the United States government should allow Dr. Burzynski to continue using experimental cancer therapies. Dr. Burzynski uses a class of drugs called antineoplastons to fight cancer, and argues that he has had great success (134). The government and American Medical Association have tried to prevent him from using these drugs on patients since these groups believe he lacks scientific proof of their efficacy. Dr. Burzynski received favorable media coverage in the United States, but not in Canada. Since the government plays a more direct role in the lives of Canadian citizens, they have less of a problem with the government regulating these experimental treatments (153).
Although this diffusion indicates the success of the movement, alternative practitioners and proponents do not always desire this type of co-optation.\(^6\)

Fifth, the number of individuals using alternative therapies indicates the sheer demographic success of the movement as measured by the level of demand for services and income generated (Tubesing 1979:188). The most commonly cited study reports that one-third of respondents in a national study had used an alternative technique in the past year (Eisenberg et al. 1993:248). In 1990 consumers spent approximately 13.7 billion dollars on alternative techniques (246). Though clients in Eisenberg’s (1993) study were more likely to be young, well educated, middle to upper class, and living in the West, all different types of people have tried these techniques (248). The movement’s broad base illustrates that the movement has been successful (Mattson 1982:135). On the other hand, this broad base makes speaking with a unified voice difficult. Some researchers argue that this is important in the early stages of a movement, so it is hard to tell whether this will continue to hurt the movement now (Tubesing 1979:221).

Sixth, the alternative health care movement has generated backlash against itself. Backlash comes from a variety of sources. Insurance companies have restricted how much coverage they will offer alternative clinics,\(^7\) or how

\(^6\)The director of the feminist women’s clinic explains that when she was involved with feminism in the 1970s, many individuals learned the “verbiage” of the movement but not the “integrity” behind it. As alternative health care developed, she believes this has happened too. She gives the example of the word “wellness.” Various individuals use this term, but it has different meanings. As the words are co-opted, she believes you lose the integrity or meaning behind the terms. To her using the discourse is less important than the ideology and identity they represent.

\(^7\)An example of insurance companies restricting insurance coverage for alternative clinics comes from the feminist clinic I observed. This clinic used to be an alternative birthing center. However, in March 1996 the birthing side of the business closed, because they “were getting paid less and less from the insurance companies. [The cost of] our malpractice insurance wasn’t going up, but the coverage was not significant enough for the Board of Directors.”
much money they will reimburse practitioners. An activist tells me that in Hawaii insurance companies are restricting how much they will pay chiropractors. Western medicine is another obvious source of backlash. Governmental agencies such as the Food and Drug Administration try to restrict herbs and vitamins. Much of the lobbying of the interest group focuses on opposing these restrictions. Activists feel it is a contradiction that the movement has gained acceptance, but still experiences opposition. However, backlash against a movement implies a certain level of success. Faludi (1991) suggests that backlash occurs when the opposition perceives that a movement has made gains, whether real or imagined. Activity from the opposition implies that the movement poses a serious challenge. The director of the professional organization said that he would "be depressed if people just ignored" him. Members take their resistance from Western medicine as a sign of success. Seen in this way backlash is not necessarily a failure of the movement. What is more important is how activists respond to this backlash.

Seventh, we should examine whether the movement has extended beyond the San Francisco, California Bay area to become a national movement. Cable and Benson (1993) argue that significant structural change is more likely to result from a coordinated, nationwide coalition of grassroots organizations (473). Though these theorists examine the environmental movement, we can ask whether this type of coordination has occurred, especially on the national level, within the alternative health care movement. Many would view the movement as a failure since the movement remains largely diffuse, uncoordinated and local. Hirschhorn, writing in 1979, argued that many alternative services remained isolated which weakened their impact (154). I found this is no longer the case. Nearly
two decades later, activists are creating extensive networks among these diffuse groups, especially as they begin to develop integrative medicine. As they make these connections, the movement will grow in visibility and strength.

Finally, we need to analyze the outcomes of integrative medicine. The alternative health care movement is beginning to transform the profession of medicine, especially as physicians are starting to explore alternative techniques and practices. The social movement literature examines how movements become co-opted by elites, while institutional theories describe the pressure institutionalized organizations face to conform to external innovations or demands (Chaves 1996; DiMaggio and Powell 1983; Meyer and Rowan 1977; Minkoff 1995). Both theories overstate the agency of one actor and the passivity of the other. To understand how both social movements and their opposition interact in a more dynamic and reciprocal fashion, I have developed a model that relies on both social movement and institutional theories. Until now I have used social movement theories to show how the movement challenges the professional ideology and practice of institutionalized medicine. Now I turn to institutional theories to illustrate how mainstream medicine can respond to these threats.

Researchers criticize institutional theories for ignoring active agency and organizational self-interest (Chaves 1996; Oliver 1991; Zucker 1991). As the state, professions, interest groups or public opinion exert pressure on organizations, institutional theorists imply that organizations adapt accordingly. DiMaggio and Powell (1983) find that organizations mimic others they deem successful, so the organizational environment becomes homogenized over time. Actors comply since the gains, especially organizational stability in the face of intense competition, usually outweigh
any required or unintended modifications (Leblebici et al. 1991:337, 360; Perrow 1972:179; Scott 1987:502-3; Selznick 1949:16; Shortell et al. 1990:28). This is why "fringe" players can not only force organizational change, but institutionalize their innovations (Leblebici et al. 1991:358-359).

To overcome this limitation of viewing organizations statically, Oliver (1991) proposes a typology moving from more passive to more active organizational responses to external threats. Using institutional and resource dependence perspectives described in the introduction, Oliver (1991) argues that organizations can acquiesce, compromise, avoid, defy or manipulate these threats. Acquiescence is the most passive response because organizations simply accede to external pressures. This includes the imitation process outlined by DiMaggio and Powell (1983). Compromise is a slightly more active response because organizations do not conform without some resistance. Administrators may comply with a new governmental policy but negotiate a reduction in the "frequency or scope of its compliance" (Oliver 1991:154; Pfeffer and Salancik 1978). Organizations can avoid changing by concealing their noncompliance, reducing the chances of external scrutiny, or escaping the environmental pressure. To illustrate, Meyer and Rowan (1977) show that some organizations only symbolically accept institutional requirements while being publicly inspected, thereby concealing their nonconformity. Defiance entails more active resistance to external pressures. An organization might dismiss or even attack a challenger in this case. Finally, organizations can manipulate the threat. This response includes the type of co-optation Selznick (1949) describes within the Tennessee Valley Authority.
I adapt Oliver’s definitions and order to apply this typology to the alternative health care movement since she does not examine social movements as an external threat to organizations. In figure 6.1 I introduce the new order of organizational responses. In this model I specify how organizations can respond generally to any type of pressure; whereas, in the next model I illustrate how Western medicine can respond to the specific threat of alternative medicine.

**EXTERNAL DEMAND**

<table>
<thead>
<tr>
<th>AVOID</th>
<th>COMPROMISE</th>
<th>ACQUIESCE</th>
<th>MANIPULATE</th>
<th>DEFY</th>
</tr>
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</table>

**OUTSIDE MODEL** | **HYBRID MODEL** | **INSIDE MODEL** |

Figure 6.1. Strategies organizations can use to respond to external demands

In my study, the external demand begins with the structural changes that have eroded physicians’ autonomy and legitimacy. Ownership and control of hospitals, for example, have shifted to financial managers. Both consumers and physicians become dissatisfied, and explore alternatives. We saw that many of these consumers turn to alternative medicine for this reason. Western medicine was not yet perceiving this alternative medical model as a serious threat. Institutionalized medicine was able to avoid a more active, collective response despite the occasional physician who would explore alternative techniques. Oliver’s version of avoidance includes...
symbolic or ceremonial changes that create the illusion of compliance; whereas, I modify this slightly to mean that the organization does not change, and they do not feel any need to do so, even symbolically. Consequently, if an organization avoids the existing normative pressure, the challengers must remain as outsiders to the system. They most likely continue to work through an alternative model or organization, as alternative practitioners have done in the past. The established institution may or may not assist the challenger in some way. The former case includes Kriesi and his co-authors' (1992) definition of informal co-optation where a group does not gain formal access but receives assistance.

As the structural changes within Western medicine continued unabated, alternative medicine gained legitimacy, and most importantly, consumers. Key studies such as that led by Dr. Eisenberg (1993) illustrated to Western organizations how significant this exodus was. Western medicine now had to respond more actively and urgently to the alternative health care movement. I change Oliver's notion of compromise to recognize that some insiders may leave their organization because they find the opposition's ideas appealing. If the institutionalized organization finds merit in the challenger's goals, institutional actors may compromise by creating a hybrid organization with the opposing group on more neutral ground. Physicians that became interested in alternative medicine for ideological reasons are most likely to join with activists in developing integrative medicine. In addition to forming a compromise between the alternative and Western models, these activists are developing an organizational innovation new to the health care

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8"New institutionalism" examines organizational innovation (Scott and Meyer 1994). For example, Chaves (1996) describes how denominations began to ordain women as clergy, especially as other religions did so. I borrow the term from this literature, but modify it slightly to mean the creation of a new organizational form, rather than the diffusion of an innovation into existing organizations.
system in the United States. Physicians are willing to risk participating in new organizational forms due to their frustrations with Western medicine, especially managed care (Shortell et al. 1990:248).

The remaining three responses take place inside the institutionalized organization, and follow Oliver’s definitions more closely. Acquiescence occurs when leaders allow some challengers to join their organization and work toward movement goals. Some Western organizations have allowed alternative practitioners to work inside their hospitals and clinics. This entails diffusion of movement ideas and personnel within Western medicine. These organizations acquiesce if they allow practitioners to work freely. By this I mean that practitioners are able to use holistic ideology in practice. Though I term this acquiescence we must recognize that these actors have varying abilities to influence their new supervisors and co-workers. Some will be able to persuade physicians to refer patients to them, while others may simply be given the space to practice.

If leaders give the opponents access, but restrict their activities in some way, then the organization manipulates the external demand. This fits Garner’s (1996) and Gamson’s (1990) definitions of co-optation. Yet, organizations can also co-opt ideas, techniques or other innovations, not just people. In this case, the organization does not give access to “fringe players,” but accommodates their ideas (Leblebici et al. 1991:359). Organizations attempt to manipulate the alternative health care movement by allowing alternative practitioners to work in their clinics without the corresponding ideology, or by using the ideas of the movement but not the activists. The former entails co-optation of personnel, while the latter involves co-optation of movement ideas. This latter type of manipulation requires more explanation. Here I am thinking about hospitals that offer nutrition or
wellness programs, or HMOs that train their own physicians to use acupuncture. Importantly, many physicians with financial motivations do not practice alternative techniques with holistic principles intact. One of my respondents said that an acupuncturist stopped training someone, "because he was abbreviating his training to incorporate it into Kaiser. Kaiser accepts anything as reasonable as long as you can see six clients in an hour. That's where it goes awry." This type of co-optation by physicians is particularly difficult since it confines activists to the "bitter role" described by an acupuncturist in the last chapter. The opposition receives credit for the movement's ideas at the same time that they exclude activists from the process of change.

Finally, leaders can defy a challenger by not only resisting organizational change but attacking the opposition. Some groups defy the new threat by attacking the alternative health care movement. Comprising a countermovement (Mottl 1980), groups such as the American Medical Association and the National Council Against Health Fraud challenge the legitimacy of alternative techniques, and restrict the movement's goals through scientific and political strategies. Figure 6.2 summarizes Western medicine's responses to the alternative health care movement.
CHANGES IN WESTERN MEDICINE
(e.g., ownership and control)

CONSUMER AND PHYSICIAN DISSATISFACTION WITH WESTERN MEDICINE

D

O

V

A

RISE OF ALTERNATIVE MEDICINE

INTEGRATIVE WESTERN WESTERN COUNTER-
MEDICINE MEDICINE MEDICINE MOVEMENT
(e.g., AMA)

+

+

ALTERNATIVE ALTERNATIVE
PRACTITIONERS TECHNIQUES

COMPROMISE ACQUIESCE MANIPULATE DEFY

Figure 6.2. Strategies Western medical organizations can use to respond to the alternative health care movement

So we do not lose sight of the fact that this is a dynamic process, I now briefly explain how the movement can respond to each type of organizational response by Western medicine. I outline these strategies in figure 6.3.
**ALTERNATIVE ACTIVISTS**
create or utilize alternative model

**INTEGRATIVE ACTIVISTS**
create new organization
to work with insiders
or utilize integrative clinics

**INSTITUTIONAL ACTIVISTS**
work with insiders in existing organizations
or utilize alternative practitioners within Western settings

**INTEREST GROUP ACTIVISTS**
lobbying & educating

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Figure 6.3. Strategies, or types of activists, social movements can use to pressure organizations and institutions

*Alternative activists* create or utilize an alternative medical model when those in power avoid their demands. I described these individuals in chapter four. *Integrative activists*, as described in the last chapter, create new organizational forms as a compromise with physicians. *Institutional activists* work from inside the system when established organizations acquiesce to, or manipulate, their demands. I borrow this term from Santoro and McGuire (1997), except that these activists attain formal status within the institution of medicine, not the government as these authors suggest. Finally, *interest group activists* respond most directly to the outright defiance of mainstream medicine. Activists lobby and educate countermovement groups, as well as governmental agencies. Activists realize that the "political reality" is that the movement needs to "work off their agenda" at times, or react defensively rather than act offensively. In my study, the interest group formed in 1991 as a result of government action against nutritional supplements. Activists successfully lobbied for the passage of the Dietary Supplement Health and
Education Act (DSHEA) in 1994. The DSHEA “created a new regulatory category for nutritional and herbal supplements which superseded the FDA’s proposed rules” (flyer). Despite the power of the countermovement, the presence of integrative and institutional activists illustrates that the alternative health care movement is in a position to exert political pressure.

Despite the increasing pressure the alternative health care movement is able to place on Western medicine, integrative medicine needs to remain a hybrid model at this point in time. This allows activists the flexibility required to refine their model. Only when they resolve the issues outlined in the last chapter will activists be able to incorporate their model into Western medicine with less chance of co-optation. Once alternative practitioners equalize the power differences between themselves and physicians, for example, they will be able to control the ideological principles at the core of their movement. Activists will no longer need to moderate their discourse to gain access, or allow physicians to separate alternative techniques from these ideas. First they must struggle to establish their role within a rapidly changing health care system (Shortell et al. 1990). Alternative practitioners in English-Lueck’s (1990) study also desired this type of autonomous, cooperative relationship. They wanted to resist absorption, as well as direct conflict, by remaining separate from Western medicine. Practitioners felt this was the only way to maintain the key components of their practices, such as the spiritual elements that distinguish it.

The argument that I have presented here has implications for social movement theory. Whittier (1995) argues that sharper changes take place in social movements during abeyance periods just prior to peak mobilization. For example, conflict over collective identities is likely during this time. Since the movement needs more participants to move from abeyance to peak
mobilization, it is unrealistic to assume that they will agree on key beliefs and identities. Whittier argues that we need information on other transitions that movements undergo. Following her call to research, I have shown that dramatic changes, in collective identity especially, take place during openings of the political opportunity structure.

During these political openings, movements can also make significant changes in their opposition. It is inaccurate and incomplete to view co-optation as a one-directional model of change. Institutionalization is not simply present or absent. Rather, there are different degrees (Zucker 1991). Acquiescence is a different level of institutionalization than manipulation, for example. In one case movement personnel and ideas are incorporated, while in the other case only ideas play a role. This argument also recognizes that elites will respond differently to the same movement. Rather than trying to answer whether a movement has been institutionalized or not, we need to ask how movements interact with different organizations and institutions. We need to recognize these different levels of institutionalization before we can explain them.

The model of organizational change I propose captures the dynamic interplay between a movement and their opposition. I suggest that this is where institutional theories can inform the social movement literature. I also show that institutionalization does not necessarily translate to co-optation. The strength and persistence of a movement’s ideology, as is the case with alternative medicine, can militate against co-optation of a movement’s personnel and techniques. This is where social movement theories have something to offer institutional perspectives.
This argument has implications for researchers that study other social movements, because all movements interact in some way with the institutions they seek to change. Research on the women's movement illustrates how institutional activists have worked within the Catholic church (Katzenstein 1995), government (Eisenstein 1995; Spalter-Roth and Schreiber 1995) and academia (Whittier 1995). Health movements around AIDS and abortion have also gained institutionalized access (Epstein 1996; Staggenborg 1991). These studies suggest that social movements do not necessarily become more conservative when they "engage" the state (Reinelt 1995). Yet, applying my model to their work could illustrate how these institutionalized organizations respond to these movements, and specify how activists have been able to use their ideology to resist co-optation. My study suggests that researchers need to address the motivations of each side. If the opposition is interested in movement ideology, they are more likely to use strategies like compromise or acquiescence; whereas, if established actors simply see the movement as a competitor they are more likely to manipulate or defy activists.

What does the future hold? It will take several years before we see how integrative medicine will develop. The possibility exists that Western medicine will co-opt alternative techniques, especially if activists divorce these techniques from holistic ideology. Stores that sell homeopathic remedies are a good example because they market these remedies for specific ailments such as the flu. It is difficult to say if this is a sign of success. On the one hand, the movement is getting these natural remedies to a mass market. On the other hand, this type of marketing contradicts holistic ideology that says practitioners need to treat clients as individuals. Also, if Western pharmacies are doing this, rather than alternative activists, then their pursuit
of profit potentially overshadows their desire to include a holistic approach. Activists know that alternative medicine is a way to practice medicine, because it takes more than techniques to get people well (Dr. Oz as quoted on The Nightly News with Tom Brokaw, November 24, 1997). If consumers use alternative techniques without the ideology, then they will likely be disappointed by the results.

The overwhelming majority of physicians who are still weary of alternative medicine have the power to prevent a truly integrative practice or equal relationship between them and alternative practitioners. Just because some physicians are interested in alternative medicine does not mean that activists have resolved all tensions between the movement and mainstream medicine. In many ways, the possible outcomes of this integrative strategy are dependent on the physicians that oppose alternative medicine. Most physicians would need more scientific evidence to change their minds about alternative medicine. "If you’re talking to doctors about yoga, you can’t talk about spirituality. You’ve got to come up with concrete physiological, biological things that a physician can wrap his mind around" (Marsha Accomazzo, Yoga instructor, as quoted in Wolf 1997:29). Activists will need to decide how much they can moderate their discourse to gain access to physicians.

Most importantly, alternative medicine has to work in practice if it is going to influence Western medicine (Tubesing 1979:187). Even though the public and some physicians are ready, alternative activists have to maintain control of the ideology and techniques for integrative medicine to work. Taylor (1979) says that the lesson of the free clinic movement is that you cannot both provide a better service and mobilize effectively to dismantle organized medicine (48). Alternative activists have their hands full, because
they are trying to do both. Dr. Robert Ivker, president of the American Holistic Medical Association, says that integrative medicine will be the “primary care of the future.” It may no longer be a question of whether this will happen, but it is certainly a question of how. I offer this study as an example of the complex relationship between a social movement, the political opportunity structure, and its opposition.
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