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Health as an Individualized Project: Gender Bio-Authenticity and Responsibilization Governance in Functional Medicine

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Health as an Individualized Project: Gender Bio-Authenticity and Responsibilization
Governance in Functional Medicine Discourse

Senior Project Submitted to
The Division of Sociology
of Bard College

by
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The Sociological Background of Functional Medicine

Introducing Functional Medicine

Functional medicine is a field of complementary and alternative medicine (CAM). Though it is unclear when functional medicine emerged as its own discrete field, the Institute for Functional Medicine was founded in 1991 by nutritionist Dr. Jeffrey Bland, who is thought to have invented functional medicine in his practices¹. However, in the year of its founding, the United States Federal Trade Commission found that Bland's companies had falsely claimed that their products could assist with metabolic issues or weight loss². In 1995, the FTC again found that Bland had made unsubstantiated claims regarding weight loss products, resulting in a civil penalty of \$45,000³. Citing these legal issues, many opponents of functional medicine have labelled the practice as quackery.

Despite its early legal troubles, however, the Institute for Functional Medicine (IFM) has grown into a nationwide network of medical professions. Though functional medicine is known to have taken root in Washington State, the IFM collaborates with the Cleveland Clinic⁴ and holds conferences around the country. On its website, it has a tool where a potential patient may locate a practitioner in every state. Although the IFM was founded 27 years ago, functional medicine has quickly rose to prominence among CAM fields.

Some of functional medicine's defining medical beliefs are in biochemical individuality, detoxification, homeopathy, leaky-gut syndrome, and anti-vaccine advocacy. Bland's *Textbook*

¹ Leyton, Edward. "Functional Medicine." *Cam Fam Physician* 52, no. 12 (December 2006). NCBI.

² Barrett, Stephen. "Some Notes on Jeffrey Bland and Metagenics." Quackwatch. Last modified September 11, 2013.

³ *Ibn.*

⁴ Institute for Functional Medicine. "About Us." *The Institute for Functional Medicine*. Last modified 2018. Accessed April 5, 2018. <https://www.ifm.org/about/>.

of *Functional Medicine* cites the retracted 1998 study by Wakefield et al⁵ that claims a link between vaccines and autism⁶. However, functional medicine is best defined by its unique way of viewing the systems within the body as interconnected, and understanding the patient as an individual. According to the Institute for Functional Medicine:

“The Functional Medicine model is an individualized, patient-centered, science-based approach that empowers patients and practitioners to work together to address the underlying causes of disease and promote optimal wellness. It requires a detailed understanding of each patient’s genetic, biochemical, and lifestyle factors and leverages that data to direct personalized treatment plans that lead to improved patient outcomes.”⁷

Functional medicine is concerned with individualizing care, but it also takes a more holistic approach to building a healthy patient when striving for “optimal wellness”. Rather than focusing on individual symptoms, practitioners aim to find the root cause of illness in patients. Instead of defining health as the absence of sickness, functional medicine practitioners treat health as a cohesive trait of the individual: happening physically, mentally, and emotionally. Most importantly, functional medicine practitioners do not believe in using any mainstream medical means to do this, such as pharmaceuticals, vaccines, or any type of chemical treatment. Instead, functional medicine providers focus on individualizing a patient’s vitamin intake, constructing nutritional plans, exercise aimed towards achieving mental balance (such as yoga), and talk therapy.

Functional medicine, or any CAM field, is generally feminized in popular conception⁸, and functional medicine deals with feminine-coded concepts such as emotional health as key

⁵ The Editors of the Lancet. "Retraction: —Ileal-Lymphoid-Nodular Hyperplasia, Non-Specific Colitis, and Pervasive Developmental Disorder in Children." *The Lancet* 375, no. 9713 (February 6, 2010): 445-46. Accessed April 5, 2018.

⁶ Bland, Jeffrey S. *Textbook of Functional Medicine*. Compiled by Peter Bennett. Gig Harbor, WA: The Institute for Functional Medicine, 2005.

⁷ “Functional Medicine.” Integrative Medical NY. Last modified 2017. Accessed November 15, 2017. <http://www.integrativemedicalny.com/functionalmedicine/>.

⁸ Sointu, Eeva. "Detraditionalization, Gender, and Alternative and Complementary Medicines." *Sociology of Health and Illness* 33, no. 3 (March 2011): 356-71. Accessed October 17, 2017. doi:10.1111/j.1467-9566.2010.01275.x.

parts of its health care philosophy. As such, and mostly by design, it constructs itself in opposition to traditional biomedicine. Considering its feminized opposition to biomedicine, gender must play a role in the everyday of functional medicine practice in a way that is simply not applicable to biomedicine.

In my research, I explore how the gender philosophy of functional medicine practitioners affects treatment strategies for their patients and the types of people that practitioners hope their patients will become. The remainder of this chapter examines relevant literature to this question regarding the regulatory discourse and gender practices of functional medicine. At the end of the literature review, I will present my research methodology.

The Biomedical Eye and Re-Conceptualizing Women's Health Care

The Institute for Functional Medicine challenges the traditional, biomedical view of the body in its approach to patient care. Often, I found that the IFM and its practitioners directly question, critique, and position themselves in opposition to mainstream medicine. The IFM and its practitioners often cite the fact that many of their patients come to them after years of failing to see results in the traditional medical framework. According to the practitioners whom I interviewed, although they see patients of both genders, they both tend to have more women than men clients. In the following discussion, I will examine gender differences in care in the traditional medical model and social movements that have challenged the mainstream model.

TRADITIONAL MEDICINE AND WOMEN'S HEALTH: A TROUBLED HISTORY

Traditional biomedical fields do not exactly hold the best track record when it comes to effectively, or fairly, treating women patients. The biomedical eye views the male body (typically white, typically heterosexual and cisgender) as the medical standard, rendering all other patients as deviant from that standard. Their biomedical deviance is managed by either correcting the problem to fit the standard or ignoring it and rendering it invisible; both achieved by either overtreating or undertreating.

Because women's bodies are viewed as deviant by biomedicine, women's bodies have historically been over-medicalized, or at least more medicalized than men's. Medicalization is the process of defining non-medical problems as medical issues: the process by which individual, emotional, or social problems become diagnosable and treatable via biomedicine⁹. Scholars argue that in many cases, medicalization is a form of social control, using a "medical gaze" to exercise social control by constructing new categories of human behavior to regulate and medicate¹⁰.

Historically speaking, medicalization marks a fundamental change in how the mind and body are conceptualized. This socio-cultural shift gained momentum in the mid-twentieth century, and led to increased scrutiny of women's bodies and behavior. With male bodies and ideas of hegemonic masculinity constituting the medical norm, everything women's basic biological differences to emotional frustrations came under the biomedical gaze. A particularly notorious example of this is when women were consistently institutionalized for these illnesses in the mid-twentieth century. Fortunately, biomedicine has advanced enough that

⁹ Waggoner, Miranda R., and Cheryl D. Stults. "Gender and Medicalization." *Sociologists for Women in Society*. Accessed October 13, 2017.

¹⁰ Conrad, Peter. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore, MD: Johns Hopkins University Press, 2007.

institutionalizing women for nerves is a thing of the past. However, biomedicine frames women's basic and normal bodily experiences as requiring medical attention and intervention, experiences such as: infertility, menopause, aging, menstruation, childbirth, and low-sex drive¹¹. The biomedical eye sees women's health issues mainly in terms of reproduction, which invisibilizes other health differences¹².

While the biomedical eye sees and treats reproductive differences, it uses its male medical standard to design and create most other treatments, particularly pharmaceuticals. In fact, pharmaceuticals are often tested on males only because women's hormones are considered a "confounding variable"¹³, suggesting that somehow, despite making up half of a population that would theoretically use a drug, women are unfit test subjects because the biological fact of their hormones constitute deviance from the biological norm. Incidentally, opioids, SSRIs, and sleep aids have more potency in women, as men's kidneys process drug compounds faster than women's¹⁴. Women are also more likely to be diagnosed with psychiatric disorders than men when complaining about the same symptoms, and are likely to receive higher dosages or psychiatric drugs than men¹⁵. These practices combined lead to women being overtreated, especially for psychiatric conditions, as we tend to see women's emotional disorders as rooted in feminized rationality and therefore needing more aggressive treatment. Overdiagnosis and male-skewed dosing also lead to women experiencing more intense side effects from drugs than men

¹¹ Waggoner and Stults, 2017.

¹² Inhorn, Marcia C. "Defining Women's Health: A Dozen Messages from More than 150 Ethnographies." *Medical Anthropology Quarterly* 20, no. 3 (2006): 345-78. AnthroSource.

¹³ Jacobson, Roni. "Psychotropic Drugs Affect Men and Women Differently." *Scientific American*, June 1, 2014. Accessed November 12, 2017.

¹⁴ Ibn.

¹⁵ Couser, Babette. "Prescription Painkillers: Know the Risks." *Women's Health*. Last modified April 22, 2015. Accessed November 12, 2017. <https://www.womenshealth.gov/blog/prescription-painkillers>.

and being more vulnerable to addiction, particularly to opioids. In this way, women's medical needs are rendered invisible by biomedicine's male medical norm.

On the other end of the spectrum, the biomedical gaze has been criticized of failing women in that it consistently under-treats them or takes their complaints less seriously. A 2003 study showed that despite reporting higher levels of pain in general, doctors treat women's pain less seriously and less aggressively than men's¹⁶- women must prove that they are as sick as male patients¹⁷. Women also wait 65 minutes to men's 49 minutes for treatment for acute abdominal pain nationwide¹⁸.

Given the inadequacies of biomedicine, it is unsurprising to see women seeking alternative health care, such as functional medicine. Complementary and alternative medicine, as a movement, is a reaction to years of gender discrimination, insufficiency, and malpractice. As such, functional medicine practitioners are rational actors, attempting to provide solutions for legitimate concerns, despite the fact that many of their treatment strategies are based upon pseudoscience. Functional medicine and other CAM fields not only construct themselves in opposition to mainstream biomedicine, but have difficulty working with biomedical doctors because of lack of communication and common discourse between the two fields¹⁹, although

¹⁶ Hoffman, Diane E., and Anita J. Tarzian. "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain." *Journal of Law, Medicine, and Ethics* 29 (2001): 13-27.

¹⁷ Fassler, Joe. "How Doctors Take Women's Pain Less Seriously." *The Atlantic*, October 15, 2015. Accessed November 12, 2017.

¹⁸ Ibn.

¹⁹ Hollenberg, Daniel. "Uncharted Ground: Patterns of Professional Interaction among Complementary/Alternative and Biomedical Practitioners in Integrative Health Care Settings." *Social Science and Medicine* 731, no. 744 (2006): 731-44. ScienceDirect.

Hsiao, An-Fu, Gery W. Ryan, Ronald D. Hays, Ian D. Coulter, Ronald M. Anderson, and Neil S. Wenger. "Variations in Provider Conceptions of Integrative Medicine." *Social Science and Medicine*, no. 62 (2006): 2973-87. ScienceDirect.

practitioners do struggle with having to use biomedical rhetoric to convey medical legitimacy²⁰.

The fact that some CAM fields, such as functional medicine, aim to operate in opposition to traditional biomedicine necessitates examination of how other successful health movements have positioned themselves in relation to mainstream medicine and how gender contributed to the operations of those movements.

CHALLENGING MEDICINE AND USING GENDER TO EVALUATE SOCIAL MOVEMENTS

The rise of CAM (complementary and alternative medicine) fields such as functional medicine follows in the tradition of women's health movements that challenge the insufficiencies of biomedicine. Some have done so by demanding invisibilized women's health problems addressed and medicalized by mainstream medicine, others have challenged the legitimacy of its authority altogether. In this section, I will discuss the value of examining the actions of successful health-based social movements through a gendered lens.

Although women's health issues are regularly over-medicalized, a significant social movement in women's health discourse was one actually requesting that a disorder be acknowledged by biomedical fields. Movements such as the postpartum depression self-help movement and the alternative birth movement utilized the gender status of its participants in differing ways to successfully affect change, socially and institutionally.

Movements such as these spurred from biomedicine attempting to expand authority over how these health problems were understood, experiencing backlash by groups attempting to

²⁰ Givati, Assaf, and Kieron Hatton. "Traditional Acupuncturists and Higher Education in Britain: The Dual, Paradoxical Impact of Biomedical Alignment on the Holistic View." *Social Science and Medicine*, no. 131 (2015): 173-80. Accessed November 9, 2017.

resist these understandings²¹. Historically, women have been excluded from constructing the medical definitions of their health problems²², particularly when doing so in opposition to the massive, masculinized biomedical infrastructure. As such, the fact that social movements such as alternative birth, postpartum depression, and now complementary and alternative medicine have been successful in securing legal and cultural legitimacy is quite remarkable and necessitates sociological investigation.

The postpartum depression self-help movement in the United States was one formed by support groups around the nation of women who experienced depressive symptoms post-birth but were unable to find sources of treatment from mainstream medical practitioners²³. Using a gendered lens to analyze the practices and framing utilized by the social movement, it becomes clear that women's positionality as a population subjugated to biomedicine's masculinized authority contributed to the success of the movement as it allowed the activists to organize around a collective identity and use the commonality of their experiences to legitimately challenge the logic of mainstream medicine²⁴. Considering the role of gender, then, is absolutely necessary to understanding the mechanics of this social movement and why it was ultimately successful in establishing postpartum depression as a condition now recognized by mainstream biomedicine. In the case of the alternative birth movement, activists used their gender position to assert the legitimacy of their claim and insist upon agency in how they could become mothers. In both movements, the cultural sanctity of white motherhood was hardly disputable. As such, the white, middle-class women fighting for postpartum depression treatment and legality of

²¹ Beckett, Katherine, and Bruce Hoffman. "Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth." *Law and Society Review* 39, no. 1 (2005): 125-70. JSTOR.

²² Inhorn, 2006.

²³ Taylor, Verta. "Gender and Social Movements: Gender Processes in Women's Self-Help Movements." *Gender and Society* 13, no. 1 (February 1999): 8-33. SocINDEX with Full Text.

²⁴ Verta, 1999.

alternative births used their unique understandings of their subjugation and positionality to win their battles. Essentially, their employments of gender in organization and framing made them achieve their goals.

Considering the similarities of these social movements to the shift towards legitimizing CAM practices (emerging in opposition to mainstream biomedicine, dominated by feminine narratives and middle-class, white women) it stands to reason that I investigate functional medicine in terms of how it uses its gender positionality to legitimize itself against mainstream biomedicine. While functional medicine does not possess the funding nor scientific legitimacy of mainstream medicine, CAM fields enjoy significant popularity. Instead of examining functional medicine on a macro-level, social movement scale, my study will examine how these practices are legitimized among practitioners on the everyday level of discourse. This approach will be valuable in that it will provide evidence as to whether these framing discourses are used on a micro level, and on whether practitioners adopt these oppositional discourses into how they structure treatment plans for patients.

Doing/ Undoing Gender in Functional Medicine

Complementary and alternative medicine (CAM) fields are typically understood as feminised. This is partially due to the fact that most CAM practitioners and clients are women, though alternative medicine fields are also coded as feminine due to its “otherness” from hard,

mainstream, biomedicine²⁵. CAM fields are not granted the same assumption of scientific legitimacy as mainstream medicine. Functional medicine, as a field, defines health as not only the absence of disease, but on the emotional well-being of the patient²⁶. As such, the field's focus on compassionate care and emotional health are associated with traditional notions of femininity, categorizing it as feminine in our cultural framework.

The gender regimes²⁷ and gender practices in the masculinized field of traditional biomedicine are well studied, so scholars are now interested in how gender is “done” in feminized CAM fields. This terminology, of course, references West & Zimmerman's “Doing Gender”, an influential work detailing how gender as a concept of social organization is sustained by individuals “doing gender”:

“Doing gender furnishes the interactional scaffolding of social structure, along with a built-in mechanism of social control. In appreciating the institutional forces that maintain distinctions between men and women, we must not lose sight of the interactional validation of those distinctions that confers upon them their sense of ‘naturalness’ and ‘rightness’.”²⁸

Essentially, we legitimate institutional ideas of gender by acting in accordance with cultural conceptions of gender at the interactional level. How we do gender, then, can be influenced by the gender regimes of our institutions. Gender regimes, a term coined by R.W. Connell, are “...the state[s] of play of gender relations in a given institution”²⁹. Institutions may encourage their subjects to do gender in ways corresponding with their gender regimes.

²⁵ Sointu, 2011.

²⁶ Integrative Medical NY, 2017.

²⁷ Connell, R. W. *Gender and Power: Society, the Person and Sexual Politics*. Stanford, CA: Stanford University Press, 1987.

²⁸ West, Candace, and Don H. Zimmerman. "Doing Gender." *Gender and Society* 1, no. 125 (1987): 125-51. doi:10.1177/0891243287001002002.

²⁹ Connell, 1987.

Given the feminization and female-dominance of CAM fields, a handful of scholars have attempted to determine how gender is done in these institutions. Are traditional conceptions of gender challenged or undone in these feminine-coded medical fields, or are they upheld?

Engaging in this debate are two conflicting studies of CAM patients. The first of these is an interview study by Eeva Sointu entitled “Detraditionalisation, Gender and Alternative and Complementary Medicines”, arguing that patients interpret their CAM use in ways that detraditionalize their gender expressions. Responding to and contradicting Sointu is Brenton & Elliot’s “Undoing Gender? The Case of Complementary and Alternative Medicine”, an interview study claiming that CAM patients understand and frame their usage in ways that reproduce traditional gender norms. I will summarize the debate over how women and men interpreted their health care as follows:

WOMEN

Sointu identifies gender detraditionalization in CAM as women turning away from “being-for others³⁰” objectification- the idea that women and femininity are defined by constants of providing care for others and critical self-scrutiny: “The discourse of caring femininity perpetuates self-surveillance...not for the purpose of self-actualization and choice but instead for adequately performing an identity that takes responsibility for the physical and emotional needs of others”³¹. This “traditional” femininity, Sointu argues, is subverted in CAM practices as patients are encouraged to perform an “individualized biography”³². Performing an “individualized biography” is the idea that one should live one’s life for herself, focusing on self-actualization and self-fulfillment, which is, Sointu claims, a direct challenge to the discourse of

³⁰ Sointu, 2011.

³¹ Ibn.

³² Sointu, 2011.

traditional caring-for-others femininity. Encouraging women to position the self at the center of their care and attention, therefore, detraditionalizes how women “do” gender- typically, feminine caretaking exists at the expense of her own self-care³³. Under this theoretical lens, women participating in CAM practices enjoy self-empowerment and self-fulfillment, effectively “undoing” traditional gender practices.

Researchers Brenton & Elliott dispute this claim, finding that rather than subverting traditional practices of femininity, the CAM approach to women self-actualization actually reinforces them. This is due to the fact that the “gendered project”³⁴ of women’s self-actualization is often contextualized in terms of intimate relationships with men, either in terms of discovering the meanings of bad relationships or “reconnecting” with the self after the end of a relationship. In several interviews, Brenton and Elliott found that women patients’ motivation for self-actualization was the hope of attracting a better male partner. Rather than discussing the faults in a bad romantic partner, women engaging in CAM used the therapeutic practices to turn inward, problematizing the self for both attracting bad male partners and allowing themselves to fall into unsatisfactory romantic relationships. Brenton and Elliott note that “doing” femininity in Western cultures revolves around performing womanhood for men. Improving the self for the sake of male partnership, Brenton & Elliott argue, certainly constitutes adherence to traditional norms of femininity.

MEN

Men using CAM in both studies seem to struggle with performing and retaining traditionally masculine identities in feminized fields of medicine. Sointu, however, finds that the

³³ Ibn.

³⁴ Ibn.

feminized therapeutic values of CAM fields encourage men to take responsibility for their health by crossing gender boundaries. Doing hegemonic masculinity in the medicinal sense means ignoring health concerns, specifically those having to do with mental and emotional health³⁵. The difficulty, then, for men attempting to engage in CAM practices is negotiating the feminized practices of engaging with emotion and retaining masculinity. According to Sointu, men do this by engaging with a narrative of responsabilization: rather than ignoring health and the body, they are taking personal responsibility by participating in the “rigorous” processes of self-care. In this way, Sointu argues that traditional narratives of masculinity are used to de-traditionalize men’s approaches to health.

Brenton and Elliott agree that responsabilization of the patient for the body is a key aspect of how men conceptualize their CAM use, especially when men participants discussed the logistics behind their choices based on scientifically-informed consumers (attempting to challenge the feminine-coding of the industry by bringing in evidence of “hard” science)³⁶. However, they found that rather than crossing gender boundaries, men framed their usage in traditionally masculine terms, justifying their usage of CAM practices by rejecting the feminine aspects of the field.

My research investigates the conflict between these two studies: whether alternative medicine discourses such as alternative medicine encourage gender detraditionalization or reinforce traditional gender expressions. My study also examines gender in CAM fields from a different, more formative perspective. Rather than focusing on how patients interpret the meaning of their gender when engaging in CAM, my study will examine the intentions of functional medicine practitioners and how they construct their treatment methods based on their

³⁵ Sointu, 2011.

³⁶ Brenton, Joslyn, and Sinikka Elliott. "Undoing Gender? The Case of Complementary and Alternative Medicine." *Sociology of Health and Illness* 36, no. 1 (2014): 91-107. doi:10.1111/1467-9566.12043.

own philosophies about gender. Instead of looking at the results of treatment, I am instead looking at how treatments are formed and how the treatments intend to affect the ways that patients do gender.

Empowerment Discourse and Responsibilization of Health

While Sointu and Elliott & Brenton's studies disagree on whether CAM fields encourage their patients to un-do or do gender traditionally, both identify responsibilization of the individual for one's own health central to the discourse of alternative medicine. Framing health as a project of individual responsibility is a product of neoliberal discourses shaping CAM practices. Men and women CAM patients seem to interpret neoliberal responsibilization in gendered ways. In the following section, I will discuss the role of responsibilization in shaping health discourse.

For the purposes of this study, I define responsibilization as a form of governmentality³⁷ that encourages its subjects to take individual responsibility for their successes, failures, and other circumstances of life. Responsibilization discourse affects the way we think about health in that we assume individuals are responsible for keeping themselves healthy, and if health fails, then that is the individual's fault. For example, when we hear that someone has lung cancer, our first thought is, "well, do they smoke?". If so, then the condition is their fault, and they must be responsible for it. The lung cancer approach to assigning responsibilization morality to health has infiltrated both mainstream and CAM health care discourse.

³⁷ Foucault, Michel. *The Foucault Effect*. Edited by Graham Burchell, Colin Gordon, and Peter Miller. Chicago, IL: University of Chicago Press, 1978.

“THE ILLNESS IS PART OF THE PERSON”: THE DISCOURSE OF INDIVIDUALIZING HEALTH PROBLEMS

_____The presence of neoliberal discourse in functional medicine is apparent in its individualization of health problems and responsabilization of individuals for those health problems. Literature has found that favorite alternative medicine treatments, such as mindfulness meditation, individualizes the act of becoming healthy by framing health practices as “do-it-yourself” routines³⁸. The individualization of functional medicine claims to be for the good of the patient, but the focus on individual responsibility for health is a fundamental aspect of practitioners’ healthcare ideology³⁹.

The responsabilization of health may serve as means to blame a patient for not doing health correctly. Health has become synonymous with morality, and health is now a means of judging someone’s self-control and self-regulation⁴⁰. For example, in our lung cancer scenario, we pass judgement on someone for receiving a lung cancer diagnosis because it means that they did something morally wrong. Because they were unable to control their need for a vice and succumbed to addiction, becoming ill is their own fault. Non-smokers can then claim the moral high ground on health, because being lung cancer-free is the direct result of having the self-control and willpower not to engage in such a vice. The same is true in narratives about obesity.

In CAM fields, this responsabilization narrative persists in conversations about mental unease, unhealthy relationships, and insecurities within the self; as well as in discourses of physical health. In Brenton and Elliott’s research, they discuss how many women turn to CAM

³⁸ Barker, Kristin K. "Mindfulness Meditation: Do-It-Yourself Medicalization of Every Moment." *Social Science and Medicine*, no. 106 (2014): 168-76. ScienceDirect.

³⁹ McClean, Stuart. “The Illness is Part of the Person”: Discourses of Blame, Individual Responsibility, and Individuation at a Centre for Spiritual Healing in the North of England.” *Sociology of Health and Illness* 27, no. 5 (2005): 628-648.

⁴⁰ Metzel, Jonathan M., and Anna Kirkland, eds. *Against Health: How Health Became the New Morality*. Biopolitics: Medicine, Technoscience, and Health in the 21st Century. New York, NY: New York University Press, 2010.

fields to heal after toxic relationships with men. Rather than focusing on the wrongdoings of abusive men in their lives, CAM patients instead chose to work on themselves, tackling their emotional flaws and insecurities to attract better male partners⁴¹- becoming the type of woman who would not be changed nor beaten by a spouse. Because this responsibility is individualized, external factors that may contribute to physical and emotional health should not affect the patient because, ideally, they have the “tools” to handle such adversity.

While this is true of many CAM fields, I would argue that this is especially likely to be true given functional medicine’s definition of health and stated strategy of treating patients. Functional medicine’s holistic definition of health seeks to locate the underlying sources of illness within a patient, rather than treating only symptoms. This leads to a philosophy wherein “the illness is part of the person”⁴², in that the individual as a whole must be cured to attain an absence of disease.

While there is significant literature on responsabilization discourse in alternative medicine and health, there is little literature on how gender philosophy affects how practitioners interpret the problematization or responsabilization of the patient for their own health, based on the patient’s gender. The intersection between adopting responsabilization discourse and interpreting proper gender expression is under-researched. This is especially true in the realm of alternative medicine, which is already neglected by scholarship in comparison to biomedicine. My study serves to fill the gaps in the research on the gendered intentions of functional medicine practitioners, how neoliberalism encourages a specific “doing” of gender, and the theoretical significance of examining how functional medicine providers gender treatment in opposition to the masculinized tradition of biomedicine.

⁴¹ Brenton, and Elliott, 2014.

⁴² McClean, 2005.

Methodology

Each chapter of this project is concerned with a different aspect of the discourse of the Institute for Functional Medicine and the practitioner participants. The first analytical chapter is concerned with how the IFM and its practitioners legitimate themselves and their field professionally and scientifically in opposition to mainstream medicine. The second chapter discusses the presence of responsabilization governance within functional medicine. The final chapter discusses how gender is governed via the responsabilization discourse that defines the moral value system outlined by the participants, and what kinds of people the practitioners try to encourage their patients to become. Each participant is identified by the IFM as a functional medicine practitioner; one of which is a IFM board-certified doctor.

This study relies on semi-structured interviews two functional medicine practitioners in addition to discourse analysis of the Institute for Functional Medicine's website. I have combined discourse analysis of educational videos and postings on the Institute for Functional Medicine's website and have used my interview data as means to interpret how the institute functions on a day-to-day basis.

My data on the Institute for Functional Medicine has been collected entirely off its website. The Institute for Functional Medicine's website is rich in information on the field in that it includes portals of informations for patients, existing practitioners, Essentially, I was most interested in studying what the IFM is trying to communicate to both the public and to their members. To examine discourse aimed at existing or prospective practitioners, I have reviewed data from "Learning Center" section of the website. I have specifically focused on educational postings or videos tagged under the "Free Learning" portion of the website, as this study has not

been funded. The “Learning Center” section of the website contains approximately forty videos aimed to educate practitioners. Some of these videos contain 45-60 minute lectures from established functional medicine doctors from the Cleveland Clinic on topics ranging from nutrition to counseling to integrating functional medicine principles into a western clinic. Other videos in the “Learning Center” of the site include introductory videos to the online courses offered to practitioners, including introductory videos and clips significantly focused on gut sensitivity and nutrition. I believe the advantage of looking specifically at the lectures and courses used to educate practitioners is that it was a helpful tool in understanding the discourse that the IFM utilizes in communication with practitioners. This was useful because it informed my analysis of how the IFM wants practitioners to treat and teach their patients to become ideal client actors. This informed the discourse analysis of my original data obtained via interviews as well.

While there was less data on the Institute for Functional Medicine’s website geared at patients in the form of informative videos, sections of the site geared at patients such as the “About Us” tab and the “Patient Resource Center” provided valuable information into the ways in which the IFM wishes to present itself to those unfamiliar with the field, and the discourse it utilizes to legitimate itself to the outsiders.

To recruit participants for my study, I intended to use the snowballing method, meaning that I would be asking the individuals who I interview to suggest additional interviewees. However, I encountered reluctance to be interviewed both among the practitioners who I spoke with and the potential interviewees that they suggested. I also encountered resistance, and even flakiness, among other practitioners who I was able to get into contact with. Despite the field of functional medicine retaining a widespread network of clinicians who frequently attend meetings

and conferences around the country, it was extremely difficult for me to find practitioners willing to speak with me, even those who were recommended by my interviewees. As a result, I have only two interviews with practitioners to analyze. However, it is unsurprising that practitioners were cautious, flaky, or unresponsive when I attempted to recruit them. As a field of medicine that is routinely criticized for quackery, the attention that functional medicine has received from journalists or health writers has been almost exclusively negative-- a quick internet search reveals dozens of scathing articles about the field. As such, it makes sense that practitioners would be wary of sociological scrutiny. In terms of my results, I cannot draw generalized conclusions given my data set about functional medicine practitioners as a whole. However, the discourse I was able to collect with the data available on the IFM's website to places the information I gathered from my participants into a somewhat broader sociological context.

Both interviews that I conducted were done so over the phone, and the conversations were recorded with the consent of the participants. The interview was designed to last approximately one hour, and was recorded via the secure app "TapeACall". I transcribed these interviews myself and stored them on a secure, password-protected laptop. Because I conducted the interviews over the phone, I emailed my participants the consent form in advance asked them on the record if they agreed to the terms outlined in the form. Each participant was assigned a pseudonym for both their name and the name of their clinic, and the geographic location of their clinics were not disclosed. I have kept transcripts and recordings of these interviews on password-protected devices.

I interviewed two participants. I included characteristics such as their exact profession, level of education, age, and years practicing. Both practitioners who I interviewed are white women, at different points in their careers. I included this information as means to find patterns

in their treatment and gender philosophy and to potentially locate the source of differences. I will also discuss the significance of the demographics of the practitioners on my findings and on the gendered discourses of the practitioners.

Fighting For Legitimacy: How the Institute for Functional Medicine and its Practitioners Position
Themselves as Legitimate Medical Actors

“If we have such brilliant western medicine, why are we all so sick and fat?”

This the question that Kylie Marshall, a licensed hypnotherapist and functional medicine health coach posed to question the legitimacy of mainstream medicine. During our interview, she presented the rising rates of ongoing public health problems as evidence that the mainstream medical model has been failing to effectively treat the patient population as a whole. Citing rates of obesity, autism, ADD/ADHD, digestive sensitivity, and mental health problems, she suggests that the mainstream, western medical model may not be so “brilliant”.

Marshall’s critiques of mainstream medicine reflects a broader trend within functional medicine providers and the Institute for Functional Medicine (IFM) of expressing skepticism toward the western standard of care. The practitioners whom I interviewed outlined the failings of mainstream medicine from multiple angles, from procedural to ethical. On the IFM’s website, videos set in clean, clinical backgrounds feature established doctors venting their frustrations with attempting to provide care within the mainstream medical framework. The discourse functions in both examples to question the effectiveness of mainstream medicine and present functional medicine as a legitimate medical alternative.

In this chapter, I will discourse how the IMF and practitioners utilize to present themselves and their field as medically legitimate. Alternative medical fields have historically been professionally ridiculed and institutionally excluded from mainstream medicine⁴³. The fact

⁴³ Whooley, Owen. "Organization Formation as Epistemic Practice: The Early Epistemological Function of the American Medical Association." *Qualitative Sociology* 33, no. 4 (September 1, 2010): 491-511. PDF.

that alternative medical fields are publicly understood as anti-scientific and coded feminine⁴⁴ means that individual practitioners and professional institutions alike must constantly present and claim medical legitimacy. Functional medicine practitioners claim such legitimacy for the sake of recruiting professionals and attracting clients that may be fed up with the mainstream medical system, but are unfamiliar or perhaps skeptical of alternative medicine. On their website, they have tabs dedicated to providing information for both groups. The ways in which they present legitimacy reveal that they are not only aware of the specific critiques of their fields, but they feel they must signal that they have greater medical legitimacy than mainstream medicine by emulating its coding, rhetoric, and in some cases, its aesthetics. In addition, functional medicine practitioners also position themselves as morally legitimate by ascribing to systems of hierarchical morality that interpret one's health as an indicator of their moral standing.

Historical Epistemological Challenges to Mainstream Medicine: The Case of Homeopathic Doctors during the 1832 Cholera Outbreak

Establishing medical legitimacy against the orthodox medical framework has traditionally been a struggle for alternative medicine providers. Battles for legitimacy between mainstream and alternative approaches to medicine are ongoing, with one notable early example being the questioning of epistemological standards surrounding the 1832 cholera outbreak in the United States. In the article "Organization Formation as Epistemic Practice: The Early Epistemological Function of the American Medical Association", Owen Whooley discusses the challenge to medical authority made by homeopathic doctors after mainstream medicine was failing to address a cholera outbreak. This challenge, according to Whooley, led to the

⁴⁴ Sointu, 2011.

established standards for medical practice being questioned and contested⁴⁵. Eventually, homeopathic and alternative medicine practitioners were able to win legislative battles, repealing licensing laws that favored orthodox medical practices and gaining equal legal footing to practice medicine. As a response, mainstream medical practitioners established the American Medical Association as means of re-establishing legitimacy via organizational, rather than cultural, practices. Eventually, mainstream doctors were able to push alternative medical practices back onto the fringes by using the organization's power to exclude alternative medicine providers from practicing in hospitals or collective clinics and used the institutional power to re-establish epistemological standards.

Whooley investigates this as a case study of how "...actors assert and advocate for epistemological claims in a cases in which epistemological standards are contested"⁴⁶. He argues that what made the homeopathic practitioners' methods of contestation so effective were their ways of adopting medical vernacular in order to successfully legitimize themselves in a cultural context by challenging whether the orthodox medical method was the most effective method to find medical truths⁴⁷. Essentially, alternative and homeopathic medical providers were able to gain social traction by engaging effectively in the cultural conversation, though orthodox doctors were better able to better dominate the field via their organizational skills.

Whooley's findings regarding how homeopathic medicine practitioners established legitimacy in the nineteenth century are comparable to the methods with which functional medicine practitioners attempt to legitimize themselves today. In Whooley's study, alternative medicine providers cited the failure of mainstream medicine to treat the ongoing cholera epidemic as a reason for the public and for the government to consider allowing a homeopathic

⁴⁵ Whooley, 2010.

⁴⁶ Ibn.

⁴⁷ Ibn.

approach to the problem. Functional medicine providers who I spoke to cited rising rates of autism, ADD/ADHD, obesity, and food sensitivity to suggest that mainstream medicine is failing to treat some key, ongoing health problems within society as a whole.

Whooley's findings also provide meaningful context to other studies on health movements that have challenged or resisted the mainstream medical model. Social movements such as alternative birth⁴⁸, the fight for recognition of postpartum depression⁴⁹, and now the rise of alternative medical fields have all experienced success because of their ability to build cultural legitimacy by questioning the mainstream medical eye⁵⁰, similarly to the holistic practitioners that Whooley studies.

However, functional medicine providers have also corrected the mistakes that caused them to be pushed out of the mainstream medical practice in the nineteenth century. By establishing a professional association, the IFM, that gives certifications, holds regular conferences, and prides itself on sponsoring laboratory research, functional medicine providers have (intentionally or unintentionally) been able to mimic the institutional example of the American Medical Association that gives them the infrastructure to develop the professional networks and organizational style necessary to presenting legitimacy from an institutional level. In addition, the IFM and its members have reproduced the nineteenth-century legitimization tactics that worked for them, such as adopting mainstream medical rhetoric and aesthetics and critiquing mainstream medicine based on ongoing public health issues. These legitimizing strategies allow functional medicine practitioners to establish themselves in both organizational and cultural capacities. In the following discussion, I will examine how the functional medicine providers utilized these legitimizing strategies in their discourse.

⁴⁸ Beckett and Hoffman, 2005.

⁴⁹ Verta, 1999.

⁵⁰ Beckett and Hoffman, 2005.

Imitation Without Flattery: How Functional Medicine Providers Present Their Work

The Institute for Functional Medicine, the organization that certifies functional medicine doctors, operates as both a professional institution and an educational center for prospective functional medicine health care providers. As such, it regularly publishes online educational videos meant to be a resource for doctors who would like to incorporate the principles of functional medicine into their practice. A key video featured in the “Learning Center” of their site is one advertising their free “Introduction to Functional Medicine” course. This video is intended to represent the Institute for Functional Medicine’s beliefs and practices, as the purpose of the video is to encourage potential practitioners to enroll in the online course. As such, part of the intention of this video is to present a sense of professionalism and medical legitimacy. In this introductory video, Dr. Patrick Hanaway, the Director of Research at the Cleveland Center for Functional Medicine, introduces himself and his field to the viewer as follows:

“Like many of you, I’m a family practitioner. I’ve been on medical school faculty, and I’m a fellow at the WAFP. But the longer I’ve practiced, I noticed that many of my patients with chronic, non-communicable diseases like hypertension, diabetes, and arthritis weren’t getting better! Even though I was following the standard of care, in many cases, the treatments weren’t working. My patients with chronic conditions wanted more. So I began looking for new ways to help them. To improve upon the standard of care, I sought ways to promote health, reduce symptoms, and improve my patients’ overall quality of life. I expanded my approach with these patients and began incorporating functional medicine’s principles into my everyday practice.”⁵¹

Dr. Hanaway’s frames functional medicine as a necessary solution to the shortcomings of mainstream medicine. He expresses in this anecdote that as a mainstream health care professional, he could not successfully treat his patients simply by following the “standard of care” (in mainstream medical terms, the standard of care is essentially the standard procedure for

⁵¹ Cleveland Clinic Center for Functional Medicine, and Institute for Functional Medicine. "Introduction to Functional Medicine." Video file, 01:50. Institute for Functional Medicine. 2018. Accessed April 17, 2018. <https://www.ifm.org/learning-center/introduction-functional-medicine/>.

treating a given condition). As such, he had to take responsibility for his practice and venture into a new field in order to be an effective practitioner. He continues, defining functional medicine and explaining its effectiveness:

“What is functional medicine? Functional medicine is an individualized, patient-centered, science-based approach that is the focus of my practice, in addition to the standard of care. The functional medicine model empowers patients and practitioners to work together to address the underlying causes of disease and promote optimal wellness. It uses the latest medical research to help clinicians design safe, effective treatments when the standard of care is not enough.”⁵²

His description of functional medicine is repeated, almost verbatim, from the Institute for Functional Medicine’s website⁵³. Notably, Dr. Hanaway feels the need to embellish that the medical discipline he is advocating for is, indeed, “science-based”. His specification that functional medicine uses the “latest” medical research to make up for the failures of mainstream medicine’s standards. However, the dialogue of the video is played over footage of clinics that look very similar to a typical, mainstream doctors offices. The footage mostly contains clips of practitioners in lab coats interacting with healthy-looking patients in clean, airy examination rooms, usually with their patients sitting on classic exam tables. As such, while the narrative of this video frames mainstream medicine as ineffectual in contrast to functional medicine’s “science-based” approach, the visuals in the video mimic the mainstream medical standard. The patients featured in the video are diverse in age, race, and gender, implicating that the functional medicine approach is meant to work for everyone.

The “Patient Resource Center” page of the Institute for Functional Medicine’s website imitates the visual themes of the “Learning Center” pages, with images of healthy, diverse patients and doctors in professional medical clinics. One image even shows a patient holding what appears to be their lab work, with the information on the page organized cleanly and

⁵² Ibn.

⁵³ Institute for Functional Medicine. "Functional Medicine." Institute for Functional Medicine. Last modified 2018.

clearly. While the visual design of the page exudes medical professionalism that imitates that of mainstream medicine, the discourse aimed at patients is designed to cast doubt onto the traditional medical model. The opening text reads as follows:

“When you visit a Functional Medicine practitioner, you can expect to spend a lot more time with them than you would with a conventional provider. You can also expect to do a lot of talking, as a large part of Functional Medicine is exploring your detailed personal and family history, the circumstances around your first symptoms, and the experiences you may have had with other healthcare providers. The Institute for Functional Medicine teaches practitioners how to uncover the underlying causes of your health problems through careful history taking, physical examination, and laboratory testing. By investing this time and effort up front, many people find that working with an IFM-trained provider helps them get to the bottom of perplexing problems that have eluded other clinicians for years.”⁵⁴

The discourse on this page aimed at patients presents functional medicine consistently oppositionally to mainstream medicine. Functional medicine is introduced to the patient reader via comparison, specifically one that differentiates functional medicine in terms of the quality of patient experience. After introducing the idea of spending considerably more time talking with functional medicine providers, the IFM moves into an explanation of why the talking is necessary-- to understand family history, the patient’s personal health history, and, finally, locating where other clinicians went wrong. Finally, the IFM suggests that its practitioners are simply more thorough when it comes to patient care because of individualized lab work and “history-taking”, which is why they are more likely to “get to the bottom” of a patient’s health problems.

When aiming its discourse towards patients, the IFM presents its virtues while simultaneously slighting mainstream medicine. Though they mimic the mainstream visual style of mainstream medicine, they also position themselves as more medically legitimate due to their different, more thorough practices.

⁵⁴ Institute for Functional Medicine. "Patient Resource Center." Institute for Functional Medicine. Last modified 2018.

The practices used by Dr. Hanaway and the IFM to legitimate functional medicine to potential practitioners are quite similar to those that I noticed from my interviewees. From the above passages, there are two key ways that the Institute for Functional Medicine established legitimacy. On one hand, they emulate the aesthetic and language of mainstream medicine. However, they also de-legitimize mainstream medicine by claiming that functional medicine is more science-based, and that the traditional “standard of care” is not seeing the body with enough accuracy or sophistication. Essentially, the Institute for Functional Medicine establishes medical legitimacy by emulating the codes set by mainstream medicine in order to de-legitimize it. The functional medicine providers that I interviewed mimicked these discourses when discussing the merits of functional medicine and the failures of mainstream medicine. However, individual providers also adopt anti-establishment rhetoric when discussing their grievances with mainstream medicine.

PRESENTING SCIENTIFIC: MIMICKING MAINSTREAM MEDICAL DISCOURSE

At twenty-four years old, Marshall is one of the younger practitioners in her field. However, she has been practicing functional medicine for four years. Previously, she worked at Evergreen Vitality Clinic as a hypnotherapist. However, she has recently decided to branch out and open up a practice of her own. Her most recent project has been creating her own health coaching business, Mindful Maternity, where she will coach couples before they try to conceive to help them produce a healthy child. When I asked Marshall what inspired her to create Mindful Maternity, she was ready for me with examples and statistics to justify her practice. She launched into the following explanation:

Marshall: “I started again because I just saw how many kids are being born with autism and ADD and how the rate, like, autism, for instance, has increased by 1000% in twenty years. And, so, I’ve had personal experiences with autism, my brother, my oldest brother,

is on the spectrum, my ex kinda thought he was on the spectrum, so I've lived really close to it, and I just see how the gut, and the health of the gut when you're born has so much to do with that, and also to do with the health of the parents, because they're passing down with the gut, right? Yeah, so conscious conception is kind of like a new, a new way of thinking about having kids, and it really stresses the idea of pre-conception, so the time before you actually conceive. That's the time that matters, that's the when you need to be detoxing, that's when you need to heal your gut. Because once, you know, once your kid is born, it's so much harder to undo that damage, and it, you know, we can talk about the stress and the heartache and the finances of that. So, you know, I have a lot of parents in my practice too that have kids on the spectrum and have food allergies, and it's just a pain in the ass, you know?"

Myself: "Yeah"

Marshall: "And anyway, then there's the bigger issue of, you know, why isn't anyone talking about the fact that autism has increased by 1000% in just twenty years, you know? So I'm doing it to create awareness but also because I feel like it really is a place where you can make a lasting change in the health of our children."

Essentially, Marshall believes that the factors that have contributed to increasing rates of autism and other neurological disorders, as well as rates of food sensitivity, are linked to the health and preparedness of the parent's bodies prior to conception. There are a few notable details about her explanation of her budding practice. First, her attitude about the importance of pre-conception responsabilizes the parents, as she suggests that through "detoxing" and "healing", parents have some level of control over whether their children are born with autism, ADD, or gut sensitivity, which she believes is the source of many other health problems for her patients. This outlook is specific to functional medicine's unique way of viewing the body; arguing that the gut health of the parents will affect the mental health of the baby sees the body as a whole, interconnected system. Secondly, the apparent assertion that children with autism or gut sensitivity are "a pain in the ass" for her patients seems to indicate that some patients come to her to ensure a better outcome after having children afflicted with these conditions.

The third notable characteristic of her response is how ready Marshall is with statistics to justify her specific concern about autism and other neurological conditions. Essentially, the first

thing she says to me in response to my question, before she touches on her personal experience or health philosophy, is a recitation of a statistic about autism prevalence. Leading with a statistic is an effective method of framing an argument, especially if one is trying to demonstrate the necessity or the legitimacy of their viewpoint. In this situation, Marshall is aware that she is being recorded about her medical practice, and therefore, it is understandable that she would want to appear as a legitimate practitioner. Thus, leading with a statistic signals her legitimacy as a clinician. In addition, the fact that she had that statistic ready to use in conversation suggests that she may consistently feel the need defend her practice, and has numbers on hand to do so.

Marshall also stresses the importance of hard science and laboratory testing when discussing how she treats her patients. When I asked her about her training and education, she responded by explaining to me why she prefers to practice functional medicine:

“I’ve gone through a healthcare certification, and it’s called, um, my certification is Integrative Medicine Health coach, so integrative medicine includes everything, right? So I’ve taken that and focused more on functional medicine, which is where the laboratory tests come from and all of that, and there’s so much science behind functional medicine, that you know, I like people to have numbers in front of them when they’re doing changes.”

In her response, Marshall signals to me that she prefers to practice functional medicine specifically, rather than integrative medicine, because it is more scientifically-based. To express this, she discusses her usage of lab work, a key tool of functional medicine providers. Ordering laboratory work is when a functional medicine provider sends out a patient’s blood or DNA sample to be tested for any individualized food inflammations or processing deficiencies. Here, Marshall indicates that the “numbers” that the lab work provides her with are imperative to her treatment style. Signalling her reliance on numbers and data in her practice conveys legitimacy by adopting the rhetoric and practices of mainstream medicine, which holds popular claim on

medical legitimacy. Marshall claims legitimacy by suggesting that her approach uses similar scientific procedures to mainstream medicine in that it relies on laboratory testing and hard data.

Dr. Karen Edwards also uses scientific rhetoric to discuss both her practice and her treatment philosophies. Edwards is a board-certified sexologist by the Institute for Functional Medicine. She runs a small functional medicine practice in Western Washington, Evergreen Vitality Clinic, where she employs a small team of hypnotherapists, nutritionists, and health coaches. While her day-to-day practice mostly consists of seeing patients, she also occasionally holds web seminars, runs wellness workshops, presents at conferences, and hosts deep immersion retreats. As a practitioner who has has a decade of experience in the field, she often reflects upon the failings of the mainstream health care industry. Most notably, she used scientific language to explain her assertion that people, in general, are not held personally responsible enough for managing their own health. Part of this problem, she argues, stems from the fact that the mainstream medical model allows people to ignore natural, scientific consequences to their actions. She explains as follows:

“Well, if you sleep with someone-sexual intercourse-with somebody, you’ve actually just had sex with every single person they had sex with. And people don’t think about that when they are sexually active. So there’s less responsibility taking for putting a condom on and using protection because they don’t think about that, you know? And then get angry when there’s some consequence to that. Or, drinking alcohol, or using cocaine or any other kind of drug, or using sugar or eating genetically modified foods, all of these things have consequences to them that are just natural, it’s just the law of physics and the law of averages, so it’s very scientific, there’s no shame and there’s not blame in that, so we put it there. A scale only gives you back your weight, measuring tape just gives you your waist circumference, it doesn’t shame you in the process. You do that for yourself, or ignore completely the consequences until it’s too late because you just shut down and don’t listen. So all of these things are just the natural laws of physics, it’s not really anything really deep, it’s just the natural consequences of actions. And, just noticing that is a real basic skill that we’re taught in science, in elementary school, and yet, choose to shut that off, which is a very interesting thing.”

What Edwards emphasizes here, that Marshall hinted at also, is the idea that the individual's actions are always responsible for the results they see in their own health. Like Marshall arguing that a patient taking responsibility for her gut health will lower the risk that her child will be born with autism, Edwards suggests that understanding the "laws of physics" and consequences of unhealthy behaviors is key to maintaining a healthy lifestyle. She implies in her language that it is a choice to feel shame about the numbers on a scale or a measuring tape, as those numbers do not actively pass judgement. At the same time, she argues that these health issues are the consequences of people's actions, the "laws of physics" that make unhealthy eating or unsafe sexual practices detrimental to one's general health. In this way, she uses scientific rhetoric to legitimize herself and her beliefs about the importance of patients being self-responsible actors.

THE THEORETICAL CONTEXT OF ESTABLISHING LEGITIMACY

In the context of Whooley's work, both Marshall and Edwards utilize and reproduce mainstream medical rhetoric to convey medical legitimacy, similarly to the homeopathic doctors in the nineteenth century. In fact, all of Edwards' pictures on her clinic's website show her wearing a lab coat. The Institute for Functional Medicine itself effectively reproduces the strategies and practices of mainstream medicine in order to establish legitimacy. According to Whooley's study, the orthodox doctors of the nineteenth century established the American Medical Association in order to create an institutional barrier to protect the field itself and to establish themselves as one stable, legitimate network of professionals. For a field vulnerable to criticism such as functional medicine, establishing a professional institution such as the IFM that handles education, research, and certifications for functional medicine providers serves as a

similar means for both establishing legitimacy and creating institutional protections for its members. In this way, the IFM and its providers are correcting for their mistakes in the nineteenth century by both working to establish cultural legitimacy and also adopting organizational practices to insulate their field by creating the support of a professional network.

CONTEXTUAL FACTORS OF PRESENTING LEGITIMACY

A potential methodological issue that could stem from this analysis is the possibility that Edwards and Marshall are presenting scientifically in order to demonstrate legitimacy for my benefit. Given the situational factors at play in these interviews, that is not outside the realm of possibilities. Both practitioners know they are being interviewed for a study on functional medicine providers, that their words are being recorded, and, they are aware that they work in a field that is routinely mocked for being anti-scientific. In that sense, it makes sense that they would both try to come off as legitimately as possible. This was especially true for Marshall in the earlier questions of the interview-- once we had talked for a while longer and she became more comfortable, she began discussing the more spiritual aspects of conception and functional medicine. However, social performativity in any context still provides reasonable data, and the fact that both these practitioners so easily slid into the role and vernacular of medical legitimacy indicates that they have had substantial practice with this type of performativity. Therefore, I can conclude that for these providers, performing legitimacy is a routine social practice.

Flipping the Script: Utilizing Medical Coding Against Mainstream Medicine

According to Whooley's study of the American Medical Association in the nineteenth century, alternative medicine providers were pushed out of the mainstream partially because of the AMA's institutional insulation⁵⁵. Today, functional medicine providers attempt to de-legitimize mainstream medicine by critiquing how it functions as an institution, arguing that the establishment of mainstream medicine and the powerful actors it surrounds itself with deserves skepticism on its effectiveness as a healthcare philosophy. Marshall and Edwards both critiqued the institutional infrastructure of mainstream medicine. When asked about her grievances with mainstream medicine, Marshall responded as follows:

“Oh... so many. I think that it's, well, I know that it's a business, so all that matters to big pharma is money, right? So they're going to create any kind of medication and pay people to make the results and the statistic look good on paper, even though it's doing a lot of detrimental, you know, stuff to the gut, or the brain, or fill in the blank. They don't care because they have a bottom line. And then they go and pay doctors, I mean not directly, but they offer free continuing education courses, and if you sell this many...or if you prescribe this much, they'll give you a free trip to Hawaii. Like that shit actually happens. So they're bribing doctors to give medicine. And in my mind, if a doctor is being ethical, they're giving people what they need, and not what a pharmaceutical company is telling them to give.”

Marshall takes an anti-establishment angle in her critique of mainstream medicine, arguing that the integrity and efficacy of doctors and their procedures has been compromised by powerful interest groups surrounding them, such as large pharmaceutical companies. Her assertion that the institutions surrounding mainstream medicine corrupt the medical legitimacy of their practices plays on an existing social culture of anti-establishment while at the same time, making a claim to moral superiority in the health world by pointing out the mainstream field's perceived corruption. Edwards echoes Marshall's sentiments while also staking out the moral high ground, saying “...and then you know, we have the FDA and the EPA and agri-business and

⁵⁵ Whooley, 2010.

the pharmaceutical industry, all of which are on a path for health-promotion, because the very basis of our culture is still on capitalism. That's gonna mean the dollar is the bottom line rather than people's health."

In this example, Edwards makes a jab at multiple high-powered institutions, not just mainstream medicine. However, the spirit of her critique is that due to the capitalist interests of established groups that handle the production and regulation of medicine and agriculture, profit will always be prioritized over healthcare. Edwards stakes her moral claim by asserting that these industries simply do not care enough about people's health to shake their "bottom line". Marshall asserts the same, actually using the same language to discuss these industries' focus on profit. The fact that both of these practitioners use the same language when critiquing the capitalist intentions of mainstream medical institutions indicates that functional medicine providers within their particular network share this common philosophy.

Both Edwards and Marshall utilize this anti-establishment rhetoric to critique the legitimacy of mainstream medicine and its effectiveness as a whole. Marshall makes some particularly pointed remarks regarding the entire American health model:

"Here's big pharmaceutical companies that run the show, 'cause they have just so much money; they control the FDA, they control the CDC, they control all of the regulations, and then I think that big agriculture, too. So like adding chemicals to our food, and genetically modified foods that aren't even real, and our gut doesn't look at them as food, they look at it as an enemy so then our immune system has to attack it, and that's why we have so much leaky gut. So big agriculture also, they control the people that regulate them. And so our country is one of the most wealthy countries in the world, and yet we're the sickest. And so, that doesn't make sense, right?"

Here, Marshall uses both anti-establishment rhetoric and medicinal rhetoric to argue against the scientific legitimacy of mainstream medicine and the industries that she believes surround it. By discussing the internal processes of the body in terms of digestion and how it handles toxicity, she positions her knowledge of medicine and the bodily health as oppositional

to, or even victimized by, the mainstream institutional model. By doing this, Marshall is trying to convey legitimacy by structuring the opposite as fundamentally illegitimate.

While emphasizing problems of institutional corruption is a meaningful cultural strategy to de-legitimize mainstream medicine, both Marshall and Edwards also critique on procedural and philosophical flaws with the traditional medicinal model in order to erode its legitimacy. Marshall takes a moment to critique the mainstream model's methods of testing, asserting that "...that's where I think so many of us are so sick, cause we're just guinea pigs. They haven't tested medication long term, they haven't tested vaccines long-term, they haven't tested antibiotics or milk long-term."

Marshall argues here that the mainstream model's insufficient testing is potentially leading to more illness, critiquing their procedural practices in a way that both demonstrates a familiarity with how testing should be done and indicates a flaw within the mainstream system. In this sense, Edwards also discusses procedural and philosophical flaws with mainstream medicine, indicating that functional medicine handles these issues in a more effective manner. When discussing her grievances with mainstream medicine, she says they revolve around "...the fact that we are all different, genetics shows us that, and we don't take a personalized approach with that model of medicine, we just look at the symptom and kind of match a drug to it."

Marshall echoes this critique, elaborating on the problems with the mainstream medical approach and the reason why, she believes, functional medicine is actually more effective. She argues as follows:

"...in functional medicine, instead of saying, oh you have joint pain, so let's give you a pill that's gonna make you not feel that anymore and make you forget about it, instead of that, let's do a lab to see why you have that inflammation...So, functional medicine, you know the point of that is get to the root. Get to the root of the symptoms, and heal from there, and so that's what they're missing- that's what western medicine doesn't do. They never talk about nutrition- I mean rarely, that's just starting now, they don't ask you what

you eat, you know- like I spent so many years with clients, and I would ask them their story, right? Like how did you end up here? What happened to get you to this place where you're so desperate that you're coming to an expensive doctor? And it's like well, I went to doctors for so long, and I'm like what did they ask you about, you know? And it's like, they didn't ask me about my diet, you know?"

While critiquing the procedural methods of mainstream medicine, both Marshall and Edwards discuss the flaws with the traditional model while simultaneously positioning functional medicine as the medically sound alternative. Both practitioners consider the traditional medical model to be ineffective in its' prescriptive approach, using pharmaceuticals as a "band-aid" for a symptom rather than addressing the problem underneath that symptom. In the interviews, both of the practitioners' discourses present functional medicine's treatment strategies as oppositional to those of mainstream medicine. Therefore, if mainstream medicine's approach to treatment is medically ineffective, then functional medicine's must be more legitimate due to its inherent opposition.

Edwards, specifically, identifies fundamental differences between functional medicine's treatment philosophies and that of traditional medicine, particularly in terms of their different underlying beliefs about how the body should be seen, by any medical model. She discusses biochemical individualism, the foundation of functional medicine treatment philosophy. Biochemical individualism is the idea that, because each individual is completely genetically unique, doctors must treat them as such. In functional medicine, this operates in practice by conducting labs to test patients for inflammation and considering a patient's health "story". This functions to individualize a patient's health plan in a way that functional medicine providers believe that mainstream doctors fail to do. When I asked Edwards about the importance of biochemical individualism in her practice, she responded as follows:

"There's a scientific necessity for biochemical individuality, there's not even a place for an opinion in there, it's just straight, like, biochemical individuality has one definition

and it's just one fact that we are not all the same person. And our fingerprints show that, our genetics indicate that, so it's not even a controversial thing, it's just a fact. We're all very different. So any medical model that doesn't take that into consideration is just ignoring basic foundational scientific fact."

In this excerpt, Edwards adopts a similar strategy to actors from movements before her that have questioned the mainstream medical model by resisting its general treatment philosophy and problematizing the way that it considers the patient as a whole^{56 57}. Here, Edwards goes farther to suggest that the functional medicine model is actually more scientifically reliable because it manages to consider individualized differences between patients in a way that the mainstream medical eye simply does not. In her words, the failure of mainstream medicine to take biochemical individuality into consideration renders it illegitimate as a medical philosophy in that it ignores "...basic foundational scientific fact". As such, she positions functional medicine in opposition to mainstream medicine in that the perspective she describes implicitly must be more foundationally scientific and therefore more medically legitimate.

Masculinized Moral Authority and Legitimization: How Presenting Scientifically and Adopting Masculinized Moral Values Legitimizes the Field.

Complementary and alternative medicine fields, such as functional medicine, are often coded as feminine. This is partially due to the fact that many of the clients are women, and also because alternative medical fields are coded as feminine due to their "otherness" from the "hard", masculinized conceptions of mainstream medicine⁵⁸. As such, part of presenting scientific legitimacy by imitating the rhetoric of mainstream medicine is also a form of

⁵⁶ Beckett and Hoffman, 2005.

⁵⁷ Verta, 1999.

⁵⁸ Sointu, 2011.

presenting masculinity in order to combat the feminized interpretations of functional medicine as a field. In addition, using masculine-coded, “hard science” rhetoric in order to challenge the medical legitimacy of mainstream medicine effectively contests the masculinity of traditional medicine and positions functional medicine and its providers as better suited to be the producers of “hard” science. As such, functional medicine institutionally attempts to position itself as the more legitimate masculine actor in the medical field. Functional medicine fights against its gender positionality in the public consciousness in order to effectively challenge the medical legitimacy of mainstream medicine.

MASCULINE MORAL LEGITIMACY

Functional medicine providers also legitimate their practices by positioning themselves in hierarchical terms of morality. This is an effective strategy of culturally legitimating a movement, and this strategy has been shared by health-based social movements in the past. One such movement was the postpartum depression self-help movement, where women in support groups all over the country worked to have their experiences recognized by mainstream medicine. A significant factor in their eventual victory was the fact that these women were able to use the cultural sanctity of white motherhood to legitimate their claims⁵⁹. The same was true in the alternative birth movement, where white, middle-class women claimed physical and moral ownership of the act of giving birth in order to advocate for their agency as expectant mothers⁶⁰. While functional medicine is a feminized field, practitioners and the IFM claim legitimacy differently than the women-centered groups of moral entrepreneurs⁶¹ before them. This is

⁵⁹ Verta, 1999.

⁶⁰ Beckett and Hoffman, 2005.

⁶¹ Becker, Howard S. "Moral Entrepreneurs: The Creation and Enforcement of Deviant Categories." In *Deviance: A Symbolic Interactionist Approach*, compiled by

partially because they are not petitioning for the medical world to do something for them. Rather, they are competing with the mainstream medical model in order to establish their legitimacy. As such, instead of playing into the femininity with which their practice is coded, they opt to demonstrate masculine-coded systems of science and morality in order to compete with mainstream medicine.

Gender, Legitimacy, and Personal Responsibility

The primary system of morality that I noticed as consistent throughout functional medicine's discourse is one that lauds personal responsibility. Encouraging personal responsibility in patients as a means of helping them heal themselves is a prominent discourse on the IFM's website and with the practitioners who I interviewed.

At the beginning of this chapter, I discussed an interview passage by Dr. Edwards, where she discussed the "laws of physics" regarding consequences to individual's actions. Edwards claims that there is no inherent judgement assigned to the negative health consequences that people experience as a result of unhealthy behaviors- they are just the "laws of physics". However, the way that she frames her argument also suggests a sense of moral hierarchy between those who choose to practice healthy behaviors and those who do not. According to Metzel and Kirkland, health has become synonymous with morality in that evaluating someone's overall health is a means of determining their capacity self-control and self-regulation⁶². The ability to control oneself is held in high esteem within a system of morality that responsabilizes the individual. The fact that Edwards cites actions associated with immorality such as premarital

Nancy J. Herman, 169-78. Oxford, England: General Hall, 1995.

⁶² Metzel and Kirkland, 2010.

sex, drinking, drug use, overeating, and general indulgences in her discussion of behaviors that contribute people living unhealthy lives indicates that she, too, understands health as a indicator of morality. In this way, Edwards legitimates functional medicine in terms of hierarchical morality. Whether intentionally or unintentionally, she fits her practice into a narrative that understands managing health as the responsibility of the individual. By using the discourse of personal responsibility in terms of consequential understandings of health, Edwards places the treatment philosophy of functional medicine as morally hierarchical, aligning it with high moral standards in order to legitimate its practices. The discourse of taking active, personal responsibility for oneself is historically male-coded. Utilizing a masculinized moral discourse offers functional medicine providers and institutions the moral authority to legitimize their field.

Conclusion

In this chapter, I have discussed the ways in which the Institute for Functional Medicine and functional medicine practitioners use discourse to legitimate their practices. The IFM and its providers utilize the juxtaposition between adopting the visual style and rhetoric of mainstream medicine and its alternative approach to legitimate its critiques by presenting scientific and professional legitimacy. Functional medicine providers and the IFM also ascribe to a model of morality that emphasizes personal responsibility. The morality of personal responsibility farther legitimates their field and practices, partially because it is masculine-coded within public consciousness. Promoting personal responsibility within the field and to the public is an attempt by the IFM and its practitioners to disrupt the popular understanding of functional medicine as a feminine-coded, and therefore, illegitimate field of medicine.

In the following chapter, I discuss the sociological significance of the discourse of personal responsibility and responsabilization governance in functional medicine. Adopting the discourse of personal responsibility is not only a legitimizing tool for the IFM and its practitioners, it is also fundamental to how they treat their patients and how they conceptualise individual health. Gendered conceptions of personal responsibility contribute to how practitioners encourage their patients to behave and how practitioners understand effective treatment.

Misery-to-Motivation Ratios and the Morality of Self-Care: The Institutional and Moral Usages
of Responsibilization Discourse in Functional Medicine

“The reason why so many people get sick to begin with is because they have an unhealthy mind-set.”

This is how Marshall diagnoses the problems her patients face. A true subscriber to functional medicine’s philosophy of treatment and the body, Marshall deeply believes that mental and bodily systems are intertwined. As such, Marshall believes that a patient’s mindset or attitude can directly affect the health of the body.

Over the course of our conversation, Marshall told me stories about her own personal health “journey”. She shared comfortably and enthusiastically with her experiences of adolescent insecurity, her coming-of-age sentiment when it came to managing her health problems, and how she felt her body positively bouncing back after ending her marriage. Overall, she exuded a sense of pride from taking care of her emotional needs and feeling her body “thanking her” for doing the necessary work to care for herself.

The story that Marshall told me was one of a young woman who managed to become a healthy individual through hard work, self-reflection, and transitioning into adult self-responsibility. In doing so, she has found herself in the position where she can actively teach her patients to come into their own in the same way that she has, and use her journey as an example of how they can take responsibility for their own health as well.

This narrative of taking personal responsibility for oneself is indicative of responsibilization governance, a regulatory practice used by institutions to encourage actors to

behave independently in accordance to the values of the institution⁶³. The ability of institutions to responsabilize their actor relies on the moral logic of personal responsibility that the organization adopts, and their effectiveness in teaching them how to become responsabilized actors. Essentially, institutions and groups utilize responsabilization governance to encourage their subjects to become a certain type of person. In the case of functional medicine, the IFM and its practitioners want their clients to become self-responsible actors who can effectively manage their personal health, be it mental, physical, or emotional. Essentially, functional medicine providers want their patients to become the type of people who have the tools and training to “heal themselves”.

In this chapter, I will discuss the discourse of responsabilization shared by the Institute for Functional Medicine and functional medicine practitioners. I argue that an essential project of functional medicine is to encourage patients to become self-responsible actors so that they can take care of themselves with minimal medical supervision. In my research, I found that the functional medicine’s foundational belief in biochemical individuality necessitates patients taking individual responsibility for their health. In addition, I found that the clinicians I interviewed described themselves as wanting to take a role in empowering their patients by constructing relationships that encouraged their patients to take personal responsibility for their health care journeys. Finally, I found that functional medicine practitioners understood taking personal responsibility as an indicator of a patient’s high work ethic, meaning that they ascribed moral value to patients who were willing to “put in the work⁶⁴” or “make an investment” into themselves. To conclude, I will discuss the gendered implications of this responsabilization and

⁶³ Rose, Nicholas. "Freedom." In *Powers of Freedom*, 61-97. New York, NY: Cambridge University Press, 1999.

⁶⁴ McKim, Allison. "Getting Gut-Level: Punishment, Gender, and Therapeutic Governance." *Gender & Society* 22, no. 3 (2008): 303-23.

empowerment rhetoric, though I will expand on the meaning of this discourse more broadly in my final chapter.

Personal Responsibility as a Practice of Health

As said by Richard Klein, in the United States, "...our health is our wealth⁶⁵". We have evolved into a time where an individual's health becomes synonymous with their moral standing. Healthiness is increasingly seen as a status that can be achieved through independent meditation practices⁶⁶ and self-help⁶⁷, so that an individual's general health is a reflection of their work ethic towards maintaining a healthy lifestyle. The judgement of individual work ethic on the basis of health is a manifestation of responsabilization governance.

Responsibilization is a form of governmentality⁶⁸ that encourages the subject to take personal responsibility for their circumstances. Examples of responsabilization governance can be seen in therapeutic drug reform programs⁶⁹, women's prisons⁷⁰, teen sexual education programs⁷¹, and in other areas and where institutions attempt to create self-policing actors. Responsibilization governance aims to make its subjects self-monitoring, so that the institution does not have to provide continual oversight because the subjects have learned to behave properly in the eyes of the institution.

⁶⁵ Klein, Richard. "What Is Health and How Do You Get It?" In *Against Health: How Health Became the New Morality*, edited by Jonathan M. Metzger and Anna Kirkland, 15-25. Biopolitics: Medicine, Technoscience, and Health in the 21st Century. New York, NY: New York University Press, 2010.

⁶⁶ Barker, 2014.

⁶⁷ Verta, 1999.

⁶⁸ Foucault, 1978.

⁶⁹ McKim, 2008.

⁷⁰ Haney, Lynn. *Offending Women: Power, Punishment, and the Regulation of Desire*. Berkeley, CA: University of California Press, 2010.

⁷¹ Karaian, Lara. "Policing 'Sexting': Responsibilization, Respectability and Sexual Subjectivity in Child Protection/Crime Prevention Responses to Teenagers' Digital Sexual Expression." *Theoretical Criminology* 18, no. 3 (2014).

In the case of health care discourses, particularly in CAM fields such as functional medicine, responsabilization operates so that the processes involved with becoming healthy involve “do-it-yourself” practices⁷² and fostering a patient’s independence from the health model itself. The philosophy behind this practice indicates that CAM institutions and its practitioners believe that the state of being healthy under the control of the individual. Literature even reveals that in CAM fields, experiencing illness is so conflated with personal flaws that discourses of individualized blame are common in alternative medicine fields⁷³. Patients are responsabilized for experiencing anxiety, unease, gut problems, insecurity, joint inflammation, and even for the psychological consequences of unfulfilling relationships⁷⁴.

Responsibilization of health in CAM fields such as functional medicine is partially due to the unique way that the Institute for Functional Medicine and its providers individualize health care. A defining aspect of functional medicine is its philosophy of biochemical individuality-- the idea that because every patient is genetically different, each patient must have a thoroughly personalized treatment plan to fit their specific health needs. As such, functional medicine practitioners believe that because each individual has different, specific health needs, each patient should be responsible for self-regulating to ensure that they care for those needs.

Responsibilization Discourse and the Institute for Functional Medicine

The Institute for Functional Medicine, the professional association that certifies functional medicine doctors and practitioners, lauds their health care model as one based upon the inclusionary involvement of the patient. The IFM invites patients to “Invest in [Their] Most

⁷² Barker, 2014.

⁷³ McClean, 2005.

⁷⁴ Brenton and Elliott, 2014.

Valuable Asset-- [Their] Health”⁷⁵ in their “Patient Resource Center” on their website, claiming that “By investing this time and effort up front, many people find that working with an IFM-trained provider helps them get to the bottom of perplexing problems that have eluded other clinicians for years”⁷⁶. In the section of their website dedicated to engaging patients, the IFM frames participating in functional medicine treatment programs as an active “investment” in the self. This is significant because the discourse that the IFM uses invokes monetary connotations in how they describe the individual putting effort into their health care. This monetary discourse therefore compares health to money in the sense that it is something that can be built, worked for, saved, and invested. It also suggests similar moral implications of how health is conceptualized to how money is conceptualized. In the United States specifically, there is certain moral authority attached to a strong work ethic that allows one to build up the security of savings, and a sense of individualized personal responsibility that accompanies that work⁷⁷. The utilization of monetary discourse in describing an individual seeking proper health care implies that the same morality described in Weber’s *The Protestant Ethic and the Spirit of Capitalism* applies to the case of ascribing personal responsibility to a patient in the case of functional medicine. In this sense, functional medicine associates health with moral virtue.

The discourse from the IFM’s website indicates that encouraging patients to take personal responsibility for their health is a key component of the clinical vision of functional medicine. The IFM advocates for “participatory medicine”, meaning that they want the patient to be an active participant in their treatment plan. They also hope that patients will take “active ownership

⁷⁵ Institute for Functional Medicine, 2018.

⁷⁶ Ibn.

⁷⁷ Weber, Max. *The Protestant Ethic and the Spirit of Capitalism*. Translated by Talcott Parsons. 2001 ed. New York, NY: Routledge, 1930.

of their wellness”⁷⁸. This discourse indicates that they want patients to become responsible for their own health circumstances. IFM states one of their primary goals as follows:

“We empower both patients and practitioners to reframe their universe of possibilities, opening up new creative possibilities for clinicians and helping patients see health as a self-determined, not a pre-determined, attribute”⁷⁹.

The concept of self-determination implicates an intention to responsabilize the patient for their wellness. The focus on self-determination instead of pre-determination is one place in the philosophy of functional medicine that breaks with the protestant ethic, though this is unsurprising given that functional medicine claims no spiritual roots in Christianity. By claiming that health is not necessarily pre-determined, and rather, a self-determined reality, the IFM essentially argues that the individual can and should be able to manipulate their wellness level simply by making the correct choices. This attitude asserts that personal health is controllable by the individual, but only by the individual. In this sense, this rhetoric indicates that the IFM aims to encourage patients to hold themselves responsible for their health and implicates them as the determinants of their own wellness.

Also notable in the above outtake is the usage of the term “empowerment”, which is common in responsabilization discourse. Often, institutions that aim to make their subjects self-responsible utilize “empowerment governance”. As Barbara Cruikshank argues in her book *The Will to Empower: Democratic Citizens and Other Subjects*, empowerment governance that encourages citizens to act “in their own interest”⁸⁰. Considering the IFM’s discussions of “active participation”, the IFM suggests that it equips both functional medicine providers and patients to

⁷⁸ “We Inspire”. The Institute for Functional Medicine. Last modified 2018. Accessed March 9, 2018. <https://www.ifm.org/about/we-inspire/>.

⁷⁹ *Ibn.*

⁸⁰ Cruikshank, Barbara. *The Will to Empower: Democratic Citizens and Other Subjects*. Ithaca, NY: Cornell University Press, 1999.

lead patients down the path of acting in their own self-interest and, therefore, empowering them to be self-responsible. The discourse of empowerment reflects how functional medicine practitioners understand their work. Instead of understanding their behavior as responsabilizing, they see their practices as empowering their patients to take “ownership” of their health.

In the following discussion, I review how the attitudes and discourse of the practitioners I interviewed mirrors or deviates from the official rhetoric of the Institute for Functional Medicine. I find that while the practitioners I interview repeat the responsabilization discourse observed on the Institute for Functional Medicine website, the comparatively candid rhetoric of the participants reveals attitudes regarding how relationships between practitioners and patients should be structured on a micro-sociological level to ensure the empowerment of a patient.

Practitioner and the Patient: The Toolbox, the Blueprint, and the Guide

Edwards’ approach to practicing functional medicine centers around fostering personal responsibility in her patients. During our interview, she voiced moral concern with the American culture around health, arguing that it allows patients to act with passivity. When I asked her if she believed that there were any obstacles that discouraged people from taking responsibility for their health, she gave the most detailed response of the interview:

“Yeah, I mean, on television... I don’t watch TV but I’ve heard that there are commercials that say, ‘ask this doctor if this pill is good for you’. So, there’s that, we’re taught... that there’s a food pyramid that works for every single person from the time we’re in elementary school moving forward, we get... as a culture we have arrested development, in the way that we tend to approach things. We’re such a litigious society that we like to blame people outside of us for whatever’s going on in our lives, so we have detachment and expectations that things will never change, and that becomes a problem for people, and we have a lot of media messages around sexuality that are untrue, a lot of myths, a lot of billboards for people to look at about the ways their lives should be that don’t really match reality...”

Edwards expresses frustration with the lack of self-responsibility and “arrested development” encouraged in patients by the way that the mainstream medical field operates. Her critique of the tendency of people to “blame” others “outside of them” for their problems indicates that she interprets the mainstream medical model as not only a structural failure, but a moral failure as well. This moral failure is caused, she believes, by subscribing to a medical model that discourages patients from taking personal responsibility for the health of their bodies.

Edwards’ desired solution encourages patients to embrace self-responsibility, both rhetorically and in practice. To Edwards, a problem with the mainstream medical model is that it discourages patients from taking responsibility for their own health. The examples that she lists as flawed concepts, such as the “ask your doctor”⁸¹ model of health care and a one-size-fits-all nutrition model. She problematizes a system of health care where patients take doctors, established medical organizations, and medical experts at their word, questioning the expertise of the mainstream medical system itself. This indicates that she desires a relationship with her clients that encourages their active involvement in becoming healthy.

RESPONSIBILIZING RELATIONSHIPS: HOW PROVIDERS STRUCTURE DOCTOR/ PATIENT DYNAMICS

Functional medicine practitioners, both those featured on the IFM website and those whom I interviewed, expressed a positive perspective on the merits of their specific approaches to their relationships with their patients. Marshall, in particular, discussed her role in her patients’ health “journeys” at length. While she once practiced hypnotherapy full-time at

⁸¹ Loe, Meika. *The Rise of Viagra: How the Little Blue Pill Changed Sex in America*. New York, NY: New York University Press, 2004.

Evergreen Vitality Clinic, she recently began building her own health coaching business. The goal of her health coaching business, Mindful Maternity, is to use the principles and practices of functional medicine to prepare couples for conception. When I asked her what a typical day in her practice might look like, she responded as follows:

“... you know, when I have a client...we talk about what their goals are, what their complaints are, what their main symptoms are, and after, we do laboratory testing to get to the root. That’s gonna be, you know, tests on food intolerances and adrenal and hormone health and GI screens, and then from there I coach them through how to utilize that information we have now from the lab to actually bring about change...So, I just take people with where they’re at, you know, so the coaching calls that I do... so, just like really holding the space for the person to do their own healing and giving them, just being a guide for them, you know, I’m giving them the tools, they’re the ones that have to actually do them”.

Marshall sees her position as a functional medicine health coach as one that encourages her patients to take their health into their own hands. Rather than detailing an authority-based relationship with her patients, Marshall refers to herself as a coach or a guide, implicating that she is curating the patient’s health journey, rather directing it. When Marshall references herself “holding the space for a person to do their own healing”, she suggests that her primary role as a health coach is to provide her clients with tools and an environment wherein healing can happen. Dr. Edwards echoed this sentiment, suggesting that her relationships with her patients function as partnerships. When asked what functional medicine means to her, Dr. Edwards responded, “...getting to the root cause and being in a collaborative partnership with my patient rather than an authoritarian, top-down model and looking at the entire emotional, physical, mental, environmental, aspects of their health... I just know more information, I’m coaching them, but I’m definitely on their same level, just not... knowledge-based.”

Here, Edwards actively dismisses a “top-down” model of medicine, implying that this is a fault of mainstream Western medicine. Instead, she asserts that a virtue of her practice is the

fact that she approaches her relationships with her clients with the belief that they can work collaboratively, as equals. This illustrates that functional medicine practitioners such as Dr. Edwards have not only reconsidered the proper relationship dynamics between doctors and patients, but they also have done so with the purpose of encouraging patients to be self-responsible. Edwards' discussion of being in "collaborative partnerships" with her patients echoes the IFM's advocacy for "participatory medicine", necessitating patients' active participation in their healing processes with their doctors. Edwards' discussion of "collaborative partnerships" with her patients in the context of her disdain for top-down medical models implies that, in her eyes, the patient will carry significantly more personal responsibility for their own healing under this model of healthcare.

The "participatory medicine" treatment strategy embodies responsabilization governance in that it places the actor in a role where it is easier for them to behave correctly when they are not under institutional supervision, while simultaneously more difficult for them to forgo the responsibilities that they undertake because they are collaborating with someone who, while technically on their "same level", provides some supervision. Functional medicine institutions and clinics are not the only organizations where collaboration is used to reinforce responsabilization governance. In punitive, therapeutic programs for women, inmates are charged with holding each other accountable for their independent growth⁸². In the punitive, therapeutic drug treatment program studied by McKim, patients had to move through levels of clinical supervision until they finally reached a phase where they were deemed responsible enough to enter the outside world again⁸³. In these ways, literature regarding responsabilization and therapeutic governance have taken note of the trend wherein responsabilization is taught under

⁸² Haney, 2010.

⁸³ McKim, 2008.

circumstances of supervision, with the expectation that actors will eventually be able to behave in accordance with the values taught to them without the necessity of supervision. Marshall even discusses when she feels comfortable “releasing” a patient, saying that she allows it when she feels a patient is ready to manage their health on their own.

Because the concept of having “collaborative relationships” with their patients bears so much theoretical resemblance to widely studied styles of responsabilization governance, it is appropriate to examine exactly how functional medicine practitioners construct and conceptualize their relationships with their patients, as well as the expectations that they have for their patients moving through their treatment programs.

LEADING BY EXAMPLE: CULTIVATING RELATIONSHIPS AND ENTREPRENEURSHIP

In the cases of both Edwards and Marshall, their comfort with encouraging personal responsibility within their patients may stem from the fact that they both consider themselves to have gone on similar wellness journeys. Dr. Edwards claims that she became interested in functional medicine because, “Just like almost 100% of other people, I got sick... and had to figure out a way outside of the Western framework to figure it out”. Marshall described in detail her relationship with functional medicine in terms of her own health, and how she believes her experience makes her more approachable to patients. When asked why she believes her patients come to her, she responded:

“They come to me, I think, because I’ve gone through what they’ve gone through. You know even if it’s not the same story, I’ve had severe depression, I’ve been 30, 40 pounds overweight and I’ve lost it, I’ve had every sort of gut issue under the sun...and so even if people don’t know that that’s what’s going on with them, they can relate to my pain, right? I can relate to the pain they’re going through. And so I think that’s what’s really helpful with having a coach or a doctor like that, like Dr. Edwards went through the same

thing, overcame her autoimmunity⁸⁴ on her own by discovering alternative ways of doing it, right? People like to hear that you've done the work, and people come to me because they have pain...and it was when I moved out of the house, when I was eighteen, and was finally on my own and responsible for myself, I was like okay, like I need to listen to everything I was taught now...Everyone has some kind of discomfort, and so hearing someone who has gone through that and is on the other side is kinda comforting.”

Marshall adopts a strategy of openness with her patients that she believes makes her a better health coach. In fact, on her Mindful Maternity website, she shares a very similar story about her wellness journey to the one she told me in our interview. Marshall wants her patients to know that an approach to health care that incorporates these ideas of self-responsibility is actually possible. According to Marshall, people hearing that she's “done the work” is a strength of her practice, and this experience makes her a better wellness guide. She also encourages her patients to take responsibility for their own health because she believes that she, and practitioners in her circle, have done it themselves.

What is also striking about Marshall's response is how she frames the actions of herself and Dr. Edwards, both of whom, according to her, managed to heal themselves. In the case of Dr. Edwards, she “overcame” her illnesses independently, not referencing any outside forces that would have helped Dr. Edwards become healthy. In Marshall's case, she acknowledges that she was “taught”, but the real change came from herself, when she became “responsible for [her]self” and decided to actively “listen” to what she had been taught. This language is entrepreneurial in the sense that she frames becoming healthy as an individualized, independent quest that only she could do for herself. Therefore, taking personal responsibility is necessary to become healthy. In this sense, she frames the responsibility for her health not in the hands of whoever taught her, but in herself because she chose to listen.

⁸⁴ Edwards defines autoimmunity as a misdirected response of the immune system wherein the system attacks the body itself.

The language utilized by both Marshall and Edwards to describe their relationships with their patients is both specifically selected and utilized with great care. They use words such as “guide”, “coach”, “collaborate”, and even “empower”, but take care not to describe themselves as “treating” or “healing” a patient. In fact, Dr. Edwards flat-out rejected the latter terms. When I asked her what it means to heal someone, she responded, “I don’t heal anybody, I don’t use that terminology. People heal themselves, I just give them clear a path and guidance and advice based on my knowledge base of how to get where they want to go, but I don’t heal them.”

The fact that Edwards felt it necessary to correct what she perceived to be incorrect rhetoric regarding her treatment philosophy shows just how carefully she chooses her discourse and the meaningfulness of that discourse. Moreover, she reclaims the correct discourse by describing her role in her patients’ lives as a guide, rather than a healer.

While Marshall does not outright reject the healing rhetoric to the same extent as Dr. Edwards, she does take care to put that healing rhetoric in the hands of her patients. Responding to the same question of what it means to heal someone, Marshall claimed that:

“I think healing someone is empowering them to heal themselves. Because that’s where it’s really gonna come from. I can’t do anything, all I can do is give them tools that will hopefully empower them so they realize they have the power to do it. And giving a little bit of guidance to steer them in the right direction, perhaps, ultimately it comes down to them. So ultimately I think it’s a matter of empowering and educating and supporting them on their healing journey.”

Like Edwards, Marshall rejects the idea that she has any agency or control over the healing “journey”, insisting that the project belongs entirely to the patient. She, too, refers to her medical advice as “guidance” and “support”, rather than “treatments” or “cures”. This is significant because this rhetoric is clearly chosen to emphasize the goal of responsabilizing the functional medicine patient. Practitioners are careful not to refer to themselves or to their health care strategies as authoritative or even healing, because of the philosophy that the wellness

journey belongs to the patient. The practitioner's role, then, is to function as less as a prescriptionist and more as a coach or a collaborative partner, therefore encouraging their patients to empower themselves to be their own healers.

The discourse utilized by functional medicine providers is very carefully chosen and employed to construct a certain narrative of practice and also to establish the relationships between providers and patients. However, the language used to describe health care strategies and also reveal telling details about who functional medicine providers want their patients to become, and how they hope their patients will get there. In the following discussion, I will outline some of these rhetorical tendencies and what they can tell us about how functional medicine structures doctor-patient relationships and what that means in terms of how patients are encouraged to behave.

Becoming Ideal Patients: Locating Problems and Living on “The Learning Curve”

In order to understand the types of people that functional medicine practitioners want their patients to become, it must be determined how they understand the “root” of these health problems and their suggested solutions for tackling these root issues. At the beginning of our interview, I asked Marshall about her position, training, and experience in functional medicine. She responded as follows:

Yeah, so I'm an advanced certified hypnotherapist, so even before I was certified I was doing some coaching in that regard. Cuz honestly that's half the battle. Like the reason why so many people get sick to begin with is because they have an unhealthy mind-set. One that sabotages them all the time with self-defeating thoughts, and, um, unhealthy patterns in that regard, and you know it's so simple once you can switch that, but you have to have the right guidance and you have to have the right tools, 'cause it's hard, it's a habit, we're programmed to by society and by society and our parents and the rest of

our family to feel a certain way about ourselves and so when we start changing that, it's a learning curve, but personally, my personal health journey, so much of it is in my head.

Marshall problematizes the mind-set of patients as the primary factor for why they experience suffering, either emotionally or physically. The locus of health problems that she identifies is unhealthy patterns of the mind. Therefore, the solution for fixing these health problems lies in altering one's mind-set. Marshall structures unhealthy mind-sets as something patients have the power to change with the right tools and guidance. This is based upon the fact that she believes the obstacles facing her health journey were "entirely in [her] head", and yet, she feels she overcame them. As such, because she took personal responsibility for altering her mind-set and changing her own self-sabotaging tendencies, her patients should be able to do the same. This discourse effectively responsabilizes patients to take control of their emotions, suggesting that taking emotional control will result in the ability to control the health of the body.

MISERY TO MOTIVATION RATIO

Before we can understand what type of people functional medicine practitioners hope their patients will turn into, we first must understand how they imagine their clients at the beginning of their health processes. Both Marshall and Edwards describe their patients as struggling with the mainstream medical system before they turn to functional medicine. As Edwards claims, her patients "have seen millions of doctors and have spent a lot of money and a lot of struggle and hardship before they find [her]"-- thus, though downtrodden, they are the type of people who may be willing to make a change in their health but are not sure how, or have found the wrong resources. Marshall, however, describes the factor that may push her patients toward seeking out medical help, eventually pushing them towards functional medicine:

“They, you know, they wanna change and so something that I have learned about is that everyone has this misery to motivation ratio, and so if they’re not miserable enough, then they’re not gonna be motivated to make big changes. You know, like cutting out gluten and dairy, no one wants to do that, but, you know, you feel you kind of have to depending on what you’re going through. So I waited until I was super miserable before I made changes.”

Essentially, Marshall is arguing that the desire become self-responsible and work on wellness within the functional medicine framework is different for each individual, but it does require a certain amount of desperation. However, even though Marshall says that this “misery to motivation” ratio is different for each individual, she discusses there being enormous gender differences in how these ratios function for men and women. In the following chapter, I will expand upon the meanings of these differences and why practitioners understanding gender differences in motivation affect gendered discourses of responsabilization.

A HEALTHY PATIENT

The goal of this chapter is to determine how functional medicine providers hope their patients will react and grow from their guidance. My interviews showed how functional medicine providers design their relationships with their patients to meet this goal, constructing themselves as guides and teachers rather than authoritative doctors. We understand how they use very specific rhetoric to try to reinforce responsabilization of their patients, and we have seen evidence of their disdain for mainstream medicine’s tendencies to not encourage personal responsibility in patients. My research has also shown how functional medicine providers perceive the processes that lead up to a patient being motivated to make change, and the ways in which taking control of one’s emotional self affects a patient’s physical health.

To conclude, we should discuss how functional medicine providers view healthy patients, or patients that have been successful. According to Edwards, a healthy patient is, “Somebody

who is going to take responsibility for their reality. So, if they have joint pain, then a healthy person is going to say: oh, I have joint pain, why do I have joint pain? And start to ask that question of why, instead of how do I get rid of my joint pain as the first focus, so, somebody that is in a collaborative relationship with their body.”

Essentially, a healthy patient is one who understands the right questions to ask in a functional medicine framework, and and who, eventually, may not need their guides to help them in their wellness. A healthy patient, according to the practitioners I interviewed, is one who will take personal responsibility for their health problems and search for the locus of these problems within themselves. This view of health responsabilizes patients in that it problematizes the self as the root of health problems. As such, self-control and self-reflection are necessary interventions for a motivated patient.

In this chapter, I discussed the discourse of responsabilization within the Institute for Functional Medicine and the practitioners I interviewed. In the following chapter, I discuss how gender is governed by the responsabilization discourse within functional medicine and how practitioners specifically encourage specific understandings and “doings”⁸⁵ of gender in their women patients.

⁸⁵ West and Zimmerman, 1987.

Governing Gender: Emotionally Control as Bodily Control and the Importance of Bio-Authenticity

Marshall's Mindful Maternity business is still in the works. Despite this, she still sees patients on a regular basis, assisting couples with preparing themselves for optimal conception. Her research on the topic spans from scientific to historical, and she has recently been looking into ancient texts on conception and polarity when it comes to "sacred conception". When I asked her what she meant by "sacred conception", she responded as follows:

"So when it comes to sacred conception, in all those ancient cultures every single one of them has some mention of nurturing that sacred bond between your two beings. So nurturing that polarity, and the stronger that polarity, the stronger the awareness is of those innate feminine and masculine traits, and the beauty of both of those, the stronger that is then the stronger the result will be, so, the stronger the baby will be."

Marshall's suggestion in her discussion of ancient rules of conception is that the strength and health of a child can be influenced, or even controlled, by the effort of the parents to both nurture their relationship and to stay authentic to their innate gender traits. The implication here is not only that her patients are able to control the health of their child, but that they can do so by paying attention to the natural, innate realities of their gender.

In this chapter, I will review how functional medicine providers responsabilize their patients with a gendered lens, and the gendered imaginations of the ideal patient. I will then use this analysis to discuss what the practitioners' discourse reveals how gender is governed and how gender is encouraged to be "done"⁸⁶ by functional medicine clinicians.

⁸⁶ West and Zimmerman, 1987.

Doing Gender in Functional Medicine

There are two competing studies regarding the way that gender is done and practiced in complementary and alternative medicine (CAM) fields such as functional medicine. The first is Sointu's "Detraditionalisation, Gender and Alternative and Complementary Medicines", arguing that participation in alternative medical fields encourages patients to detraditionalize the ways in which they "do" gender. However, conflicting literature by Brenton & Elliot entitled "Undoing Gender? The Case of Complementary and Alternative Medicine" argues that patients that engage in CAM use reproduce traditional gender norms. The goal of my study is not to interpret how functional medicine patients interpret gender from participation in these fields, but how functional medicine providers and institutes encourage gender to be done.

Sointu argues that traditional gender roles for women are upended in CAM fields due to the encouragement for patients to focus their growth on the self rather than what she refers to as "being-for others"⁸⁷ objectification-- essentially, that women and femininity are defined by their relationships to others, be those relationships with children, spouses, or other familial links. Sointu finds that instead, women patients in CAM fields are encouraged to perform an "individualized biography"⁸⁸, focusing on self-actualization and self-empowerment rather than adopting a caring-for-others role of femininity. In this way, Sointu argues, CAM fields encourage their women patients to detraditionalize how they express, or "do"⁸⁹, their gender.

Research that examines therapeutic organizations in which women are treated have also documented self-empowerment based programs and de-traditionalization rhetoric. In McKim's "Getting Gut-Level: Punishment, Gender, and Therapeutic Governance", she documents how

⁸⁷ Sointu, 2011.

⁸⁸ Sointu, 2011.

⁸⁹ West and Zimmerman, 1987.

women inmates in therapeutic drug-treatment programs were encouraged to focus on themselves and try to ignore external relationships, even with their children. She writes that “[n]ormative expectations that mothers discipline, care for, and sacrifice for their children contradicted the program’s vision of an ideal, autonomous self”⁹⁰. In other words, it is a pattern that organizations and programs concerned with empowering women advocate for an idea of responsabilized autonomy that encourages women to distance themselves from traditional conceptions of femininity.

However, Brenton & Elliot’s study of CAM fields argues that rather than de-traditionalizing gender roles, the discourse they examined reproduced traditional gender roles. This is due to the fact that, according to Brenton & Elliot, the practice of problematizing women’s relationships, particularly their romantic relationships, contextualizes women’s health problems on the basis of their relationships with men-- in addition, they found that many women patients were interested in doing self-work in order to attract a better male partner⁹¹. Noting that doing femininity in the Western framework often involves performing womanhood for men, Brenton and Elliot interpreted this trend as an effective re-traditionalization of gender norms.

In the findings that I will discuss in this chapter, I argue that functional medicine providers neither attempt to encourage their patients to detraditionalize nor adopt traditional gender roles. Rather, functional medicine providers want their patients to change the ways in which they express, or “do”, their gender. Practitioners did not want their patients to conform to gender stereotypes. However, they did believe in innate, natural differences between the sexes. As such, they wanted their patients to behave with gender bio-authenticity, considering and listening to their “biological” feminine impulses towards empathy, maternity, and emotional

⁹⁰ McKim, 2008.

⁹¹ Brenton and Elliott, 2014.

vulnerability while simultaneously subverting traditional gendered practices in favor of focusing on the self.

Gendered Responsibilization: How Gendered Notions of “Empowerment” Affect How Functional Medicine Providers Encourage Self-Responsibility in Patients

For the purposes of this study, I define responsibilization as a form of governmentality⁹² that encourages the subject to take individual responsibility for their circumstances. Research on responsibilization as a form of governmentality is extensive, particularly in which organizations and institutions encourage their subjects to become self-governing individuals.

Responsibilization governance functions to shape how subjects act by teaching them to monitor themselves and giving them the information and tools to do so, so that the institution does not have to constantly oversee them⁹³. As I discussed in the previous chapter, responsibilization governance applies to the case of the Institute for Functional Medicine and its providers in that it encourages patients to be “empowered” to take responsibility for their own health care by giving them the “tools” and “blueprints” to do so independently. In the following discussion, I will outline the ways in which these efforts towards empowerment reveal gendered conceptions of what it means to be a responsibilized actor for the functional medicine providers that I interviewed.

⁹² Foucault, 1978.

⁹³ Rose, 1999.

MOTIVATED WOMEN: RETREATS, EMPOWERMENT, AND THE INDIVIDUAL WITHIN THE GROUP

Edwards and Marshall both claim that they have more women patients than men, and that in general, they find that women are far more likely to seek out treatment earlier than men do. This has led them to believe that women patients are more motivated than men, or, at least, have lower “misery to motivation ratios” than men-- according to Marshall, men tend to “tough up” symptoms rather than seek medical attention. In the past, Edwards and Marshall have worked together in organizing “deep immersion retreats”, where patients will do extensive group therapy for four to five days at a time. Marshall describes these deep immersion treats as follows:

“Watching other people’s healing is healing. So I love doing group work, in fact I’m actually working a retreat in a couple of weekends on the San Juan Islands with Dr. [Edwards], and I’m apprenticing her while she does these retreats where she gives them all of their labs beforehand and they go over some of them beforehand, but then they come up to the islands for four days and...I give them healthy individualized meals. And it’s setting them up to go back home and know how to do the stuff themselves basically. And also every single day we do a lot of group work and emotional processing within a group and it’s amazing.”

These deep immersion retreats are means of extending the training and learning that functional medicine patients go through in order to take responsibility for their own health care needs. This is evidenced by the way that they operate. Taking the principle of biochemical individuality as the center of functional medicine’s health care philosophy, patients are handed back their individualized lab work before the beginning of the retreat, which prepares patients with the “blueprint”, as Edwards describes it, with which to understand their individualized health care needs. The meals, then, that Marshall prepares, are individualized to compliment the health needs of each patient. However, despite this belief in biochemical individuality, the rest of the retreat is focused on group therapy. As Marshall believes that “watching other people’s healing is healing”, she believes there are strengths to working with multiple patients as a group,

rather than just focusing on their individual health needs. Edwards suggests that working in groups may also help patients responsabilize themselves by drawing inspiration from one another. When I asked her about the merits of group therapy, she responded that, "...with group, people get to hear other people's stories, and hear questions asked that they may have not even thought of for themselves, they get to understand that they're not isolated in their own suffering, and help them kind of join the sea of humanity that we are instead of thinking that they're the only ones with these problems. Those are the benefits of a group."

While Edwards uses the characteristics of biochemical individualism to guide her patients towards wellness, she believes that the suffering of her patients is ubiquitous and that there is an inherent benefit in joining the "sea of humanity" and using other people's experiences and growth to help heal oneself. In this way, this type of group work responsabilizes patients not only to focus on their own personal efforts towards wellness, but to try and assist and listen to each other. In this way, patients have an interconnected responsibility within these retreats.

However, these retreats are not made up of a diverse group of patients. Typically, the type of clients who will go on these retreats are white, upper/middle class, middle-aged women. As Marshall says, "women are always the first ones to start asking questions, and they tend to be 40 and up". When I asked her about what makes the patients that go on these retreats unique, she responded with the following observations:

"Well, the last one we did was people who were pretty sick, and their pain was really, really big so therefore their misery to motivation ratio was also really big. They have to pay a pretty good amount of money to come and be there, and so it's someone who's willing to make an investment in themselves, which any kind of training I've done is expensive, and you just understand that 'I'm paying to grow, I'm doing this because it's an investment in myself'. So someone that's willing to make a special investment, someone that has a lot of misery to motivation, and someone that's open..... so these people are, even if they haven't consciously realized it, their self conscious and their higher self is guiding them towards something that's going to challenge them so that they stop getting in their own way. And that's what's beautiful, and so being in a group of

people and being in a space where everyone is there doing the same self-introspection and self-work.”

Here, we see that the traits that Marshall observed in her women clients, such as the fact that they may be more “in-tune” with their emotions and more easily motivated by their misery, makes them the type of patients who are ready to “make an investment” in their healthcare. The “good” patient, then, the one who is ready to make an extreme commitment to her health and is motivated to make such changes, is someone who has enough misery to invest a great deal in one of these retreats. In the eyes of Marshall and Edwards, these are virtues. After all, Edwards critiques people who place blame “outside themselves”, and encourages that her patients take responsibility for their health care needs. However, these retreats are designed for women who, although open to challenging themselves, tend to “get in their own way”. The purpose of these group retreats, then, is to attempt to present women with the instruments that will help them get out of their own way. At the core of this is the belief that, through taking control over one’s emotions, women can subsequently control the health of their bodies as well.

DEEP IMMERSION RETREATS AND OTHER THERAPEUTIC PROGRAMS FOR PROBLEMATIZED WOMEN

The methods that Edwards and Marshall describe using on these immersion retreats are similar to other institutions wherein women are treated for either health or emotional problems as groups as a way of teaching self-responsibility, introspection, and even empowerment. Most notably, literature surrounding therapeutic treatment programs for women offenders describe similar discourse and organizational structures used to responsabilize their patients. In a study of a punitive drug treatment program for women offenders, McKim discusses how the program encouraged its subjects to become autonomous and self-reliant citizens. Similarly to how

Marshall and Edwards believe their patients need guidance in order to “get out of their own ways”, the women being treated by these punitive programs need the therapy, according to the staffers, to build themselves up enough in order to become autonomous, responsible, and independent. In both scenarios, though one is voluntary and one is punitive, there is the sense that women need situations of true isolation from the outside world in order to engage in the type of self-focused, introspective growth that the organizations feel is necessary for their evolution into responsabilized actors.

A key similarity between these immersion retreats and punitive drug treatment centers for women is the fact that both of their structures center around group therapy. Edwards and Marshall described group therapy in terms that made it quintessential to intensive individual healing. Marshall even argues that observing other people healing is healing in and of itself, and that one can progress simply by actively listening to other people’s therapeutic processes because everyone is there for the same purposes of “self-introspection” and “self-work”. Edwards echoed this idea, adding that group therapy places problems into context for individuals, so that these women can relate to each other and join the “sea of humanity”. Though punitive drug treatment programs for women also relied upon group dynamics in their organizational outline, they did so mostly to encourage interpersonal accountability between the women in the programs. In McKim’s study of therapeutic governance in a women’s punitive drug treatment center, women signed “helping hand contracts”, agreeing to monitor each other’s behavior to support their recovery”⁹⁴. Lynn Haney also writes of inter-client accountability programs in therapeutic women’s treatment groups, though those accountability programs actually corroded feelings of community or solidarity within the treatment center⁹⁵.

⁹⁴ McKim, 2008.

⁹⁵ Haney, 2010.

The scenario created within these retreats mimics those of punitive institutions wherein their women subjects are responsabilized via therapeutic governance⁹⁶, a type of governmentality that problematizes and attempts to empower the “self” in order to encourage the subject to evolve into a responsabilized actor. A key trait of therapeutic governance is empowerment discourse, wherein institutions “help” their subjects by encouraging introspection and self-discipline, in order to become the a self-governing subject. Empowerment discourse also functions to responsabilize the subject⁹⁷. Functional medicine’s approach towards responsabilization is indicative of therapeutic governance-- discussions of giving patients the “tools” to “heal themselves” or even free themselves from requiring farther medical care.

While the functional medicine practitioners I interviewed described encouraging their patients to engage with their emotions as a way of healing both their physical and mental pain, both practitioners put a unique emphasis on the ways that unhealthy relationships, particularly with men, can harm a woman patient’s general health. As such, functional medicine practitioners may operate similarly to punitive program staffers in that they share skepticism over whether relationships are beneficial to a woman’s project of self-introspection, self-healing, and self-empowerment.

EMPOWERMENT AS A ONE-WOMAN PROJECT

A key theme in the goals that these functional medicine practitioners express for their patients is that of empowerment: empowering them to heal themselves, empowering them to be responsabilized, and empowering them to keep up these positive habits in the future. However, it would be useful to examine what exactly this empowerment looks like, how functional medicine

⁹⁶ McKim, 2008.

⁹⁷ Cruikshank, 1999.

practitioners encourage it in their patients, and what factors contribute to motivated patients “getting in their own way”.

Because functional medicine practitioners believe that all systems of the body are interconnected, they believe that emotional problems can affect physical problems, and vice versa. Because of this, they believe that inquiring about emotional problems will lead to the root of a patient’s misery, and, that physical health problems can be treated by gaining control over the emotional self. Interestingly, Edwards and Marshall have found a similar locus for much of their women patients’ ailments. When I asked Edwards how functional medicine treats what mainstream medicine misses, she responded as follows:

“It looks at the emotional, environmental...for example, a woman’s satisfaction with her primary relationship is going to impact her libido level. The number one root cause for low libido in a woman is being dissatisfied inside of her relationship. And that’s not ever explored in a Western model. It’s siloed in terms of specialities, so that would go under the jurisdiction of a psychologist, and so a medical provider would never even ask the question, are you happy in your marriage, you know? Which is ridiculous.”

I found it peculiar that failing to take into account the dissatisfaction of women within marriages would be the first example that a functional medicine practitioner would use when describing the flaws of medical practices in the Western model. However, Marshall repeated this sentiment, using her life experience as evidence of the physical harm that a unfulfilling relationship may bring:

“...personally, my personal health journey, so much of it is in my head. So much of it. And so... I finally feel like I’m at a place where I feel about 100%, and I can’t say I’ve been there ever...Even as like a 12 year old. And as a 12 year-old, not wonder I wasn’t feeling good. I had a stepdad moving in that I didn’t like and my dad moved to Utah, right...So then what happens is that all of that stress floods our body and that creates hormone imbalance...then it’s this vicious cycle because the mind is in the wrong place. But anyway so I...I’m happy to share that I recently ended my marriage because I realized that as much as I love my husband, there were other pieces that were making me really really anxious...But since I’ve done that, my gut health and my energy have been like, 100% better. And that’s all that changed. And I hear that all the time, and this is kinda sad, but but I hear that all the time from clients that like- once you start listening to them

and you hear their story, you're like- well, the marriage is the problem, clearly, like you don't feel supported at all, but you can't say that, necessarily, so you have to gently point that out, like, where do you think the root of this is? 'Cause again, the basis of functional medicine, it doesn't matter if it's physical, emotional, or spiritual, it's, what's the root of this symptom? And so if I have chronic anxiety, what's the root of that? And to me, I feel like my marriage was a big part of it."

Overviewing Marshall's personal story, she attributes her physical and emotional problems over the years to unfulfilling relationships with men specifically, involving her father, her stepfather, or her ex-husband. She sees the same patterns within her patients, but she still tries to approach the problem in a way that responsabilizes her patients. Rather than telling a patient that she either needs to work on or end their marriage, she tries to nudge them towards that realization by asking them leading questions. Although she shows cynicism towards the effect that many relationships may have on women's overall health care, she still attempts to coach women into seeing that for themselves, therefore allowing them to be in charge of their own health and empowerment.

While the approach of allowing women patients to come to conclusions about their relationships on their own adheres to functional medicine's general philosophy of responsabilizing patients and allowing for introspection, the belief that women are better off without their relationships echoes the responsabilization style of punitive treatment institutions. As such, functional medicine practitioners share the same skepticism towards the benefit of external relationships for the self-actualization of women clients as staffers in punitive organizations.

Placing these immersion retreats in the context of literature on responsabilization and power in women-centered treatment programs provides valuable insight into what the processes that we deem necessary for women's empowerment and self-actualization. As McKim notes earlier, styles of therapeutic governance that discourage women's relationships for the sake of

empowerment actually adopt masculinized ideas of what empowerment looks like. As traditional notions of femininity define women in terms of their relationships to men and children, efforts to empower women by encouraging severance of emotional relationships effectively frames empowerment as a masculine practice, so that women must shed aspects of femininity that are socially understood as “weaknesses”. Organizations that attempt to teach women to empower themselves via responsabilization encourage adopting masculinized traits while simultaneously providing inter-group connections that only encourage emotional dependency within a group setting.

It is true that a deep immersion retreat lead by two functional medicine practitioners is not fully comparable to punitive drug treatment programs for women. However, these examples of other immersive, isolating therapeutic programs are relevant to the broader narrative regarding gender and responsabilization that informs our understandings of how women are therapeutically managed and responsabilized. The responsabilization and empowerment narratives accepted by both these institutions assume a gendered conceptualization of responsabilization itself as oppositional from femininity. This is particularly true in McKim’s case study, where she finds staffers discouraged the women under their care from concerning themselves with their children or romantic interests, as they wanted the women to focus exclusively on the “self” in order to become a responsabilized subject. She writes that this take on responsabilization, citing Jill McCorkel, “relies on the idea that women’s selves (in comparison to men’s) are profoundly deficient and irrational, so treatment techniques gear them away from feminine emotionality and dependency”⁹⁸. The discouragement or skepticism of personal relationships that the providers I interviewed expressed also mimicked the trend observed by Sointu in her study of how CAM patients interpreted their use as being self-focused, rather than revolving around traditional ideas

⁹⁸ McKim, 2008.

of nurturing femininity⁹⁹. The alignment of the trends I found with how my interviewees viewed relationships and the findings of these comparable studies suggest a broader gendered trend within the responsabilization narrative that encourages women to cease traditionally feminized behavior in order to do responsabilization. As such, responsabilization practices directed at women actually encourage an adoption of masculine traits, meaning that self-responsibility and strength in empowerment is morally equated with masculinity, rendering traditional femininity to be a less morally authoritative expression of the self.

Gender, Gender-Blindness, and Individuality

I was surprised to find that, initially, the practitioners I interviewed initially took an individualized stance when it came to questions of gender and treatment. Edwards was particularly individualizing of the patient. When I asked if she takes gender into consideration when devising a treatment plan for a patient, she responded as follows:

“No, because you’re treating the person, so you know, I’m not going to prescribe bio-identical estrogen to a man, if that’s what you’re asking me, but that wouldn’t even come up because if I listen to their story and look at their lab data it’s not gonna be one of the things that I want to do. So, yes, there’s gender specificity in terms of what your interventions are, but it’s not like the way that you approach it is different.”

Essentially, Edwards argues that due to her focus on biochemical individuality, taking an individual’s gender into consideration would never occur to her, save for accounting for basic biological differences. In this passage, Edwards’ view of the differences between men and women is centered in biological determinism. Marshall repeats this sentiment when I asked her the same question about whether gender affects the way she constructs treatment plans:

“You’re gonna be- I don’t really think about gender necessarily when I’m working with someone, other than their hormones are gonna be different. On a scientific level, they’re different. But on an emotional level, you treat it all the same. Even if men have different

⁹⁹ Sointu, 2011.

themes in their problems or their emotional pain than women, you're still gonna treat it the same. You're gonna get to the root... for hypnotherapy, you talk about what emotions are coming up, then you can actually do age regressions to go back in time and figure out where that pattern began. But it doesn't matter if you're male or female in the regard."

Marshall echoes Edwards' primary focus on the essential biological differences between men and women. I found it curious that in the cases of both Edwards and Marshall, they adopted a similar removed, biological standpoint to understanding men and women as mainstream medicine. At first, I assumed this was another strategy to imitate "hard" science in order to position themselves as scientifically legitimate. However, soon both practitioners began to segway into how biological circumstances impact the fundamental differences between men and women in ways that reflected biologically deterministic views of gender behavior and expression. When I asked Edwards whether men and women have fundamental differences, she responded as follows:

"Yes. Men have penises, women do not... I mean I don't know what you mean (laughs). I mean there's gender stereotypes, but it got that way for a reason... so men have more testosterone than women, women have more estrogen than men, so yeah, there are some definitely... our brains are wired differently, there's your corpus callosum in women so they're able to multitask more and take in more information and hold it at the same time, but then they also hold on to their emotional hurt longer than men do. So that has an impact on everything."

Although Edwards begins by asserting that her treatments focus on the individual and she does not generally take gender into account, she believes that there are biological circumstances that cause innate, natural differences. The most alarming aspect of her answer is the indication that she generally believes in "gender stereotypes", as they "got that way for a reason"-- the reason being that they are biologically determined. Indeed, Edwards asserts that because male and female brains are "wired differently", traditionally feminized behaviors such as experiencing more intense emotions are a natural consequence of the sex differences in the human brain. This

is an example of how the functional medicine providers I interviewed understand gender authenticity based on biology.

According to both Edwards and Marshall, these differences between men and women affect the types of issues they come to them with. While they both claim that men and women come to them with emotional pain and that they take an individualized approach to treating that pain, men and women often come to them with different, gendered trends of complaints. When I asked Marshall about gender differences in complaints, she responded:

“Yeah, women particularly it comes down to appearance, men... men tend to be concerned, and this is an older demographic, like 40 or above, that their virility is going away, like men don't like that, so it's a hormone issue and an emotional one, but they tend to be more concerned about that. And I find it takes men way, way longer to get to a coach or practitioner because men are taught to tough it up. And so I find their misery to motivation ratio is a lot higher than women's. And that, women, we're emotional beings, and our femininity inherently makes us more sensitive and more in tune with ourselves. Once again, our culture doesn't encourage men to be in tune with themselves at all, nor women, but we're born with that to some degree, it's a skill, we're maternal, we're empathetic, we're emotional... but yeah I find that women get concerned when their appearance is affected. So when they start losing hair because of adrenal issues or hormone imbalance, they don't like that. For me, my biggest misery was that I was overweight and that I had acne, right? And that's where I got motivated because I didn't want to have acne anymore. I could deal with the anxiety all day long, who cares about that, who cares about my happiness, I wanna look good (laughs). That's our culture. So I think it takes men a lot longer to get to me, to get to anyone, really, their concerns tend to be if it's a big issue, like if it's making them have erectile dysfunction, or like really physical pain. They're not as concerned with the emotional pain, at least I find.”

Curiously, Marshall's approach to understanding gender differences of complaints with her patients involves a combination of biological determinism and an understanding of social pressures to conform with a specific gender standard. On one hand, she discusses the social pressures on men to “tough it up” and not seek treatment about emotional problems, noticing that they are more likely to visit a doctor when it is a problem regarding their masculinity and not engaging with the feminized, emotional side of treating erectile dysfunction. Marshall's functional medicine approach to erectile dysfunction is rather different than that of mainstream

medicine in that it incorporates emotional healing, while mainstream medicine's approach focuses more on fixing the "broken male machine"¹⁰⁰. Functional medicine, therefore, challenges the ways in which men's health issues are constructed and challenges the ways they are masculinized.

On the other hand, Marshall discusses examples of feminine-stereotyped traits that she believes are natural and part of female biology. The traits that she cites as women being "born" with-- femininity, maternity, and empathy-- reveal her having a similar belief about biologically determined expressions of gender as Edwards. This belief in innate, biologically determined gender traits founds the practitioners' ideology of gender bio-authenticity.

Despite Edwards' apparent belief in biological determinism, she discusses less of gender difference of complaints that her patients come to her with. When I asked her about whether any such differences took place, she responded that, "No. They both come in tired they both come in because they're anxious, they both come in because they're depressed. Obviously, a woman's not going to have erectile dysfunction, but they will come in with special issues that are gender-specific, but they're still special issues. So probably not."

Despite claiming to notice no tangible difference between the complaints of men and women patients, Edwards does point out one difference that Marshall considers to be significant of the nature of men's complaints: the trend of coming to practitioners for help with erectile dysfunction. As such, we can conclude that the gender differences Marshall describes are consistent between functional medicine providers, at least in the area where these practitioners specialize (conception and sex).

In these discussions, both practitioners based the fundamental differences between men and women on their biology, be it physiological or their brain chemistry. While this remained

¹⁰⁰ Loe, 2004.

true in most of Edwards' discussions on gender, Marshall was willing to expand into the emotional and even spiritual aspects of fundamental gender differences. In the following discussion, I will analyze how these practitioners, particularly Marshall, conceptualized fundamental gender differences based on bio-authenticity in her consideration of innate traits of femininity and masculinity in shaping how patients should behave..

Sacred Polarities: Legitimizing the Fundamental Differences of Gender

The purpose of Marshall's "Mindful Maternity" clinic is to prepare couples for conceiving strong children via detoxing, therapy, and diet preparation. A large aspect to preparing the couples, to Marshall, is based in strengthening their relationship with each other. When I asked her about whether men and women have fundamental differences, she responded as follows:

"I was just actually reading about that... I'll talk about it in the context of conception. So in ancient cultures always had this idea of the polarities, right? Like feminine and masculine, yin and yang, shiva shakdhi, these opposites, they inherently have different qualities because they're meant to balance each other out. And so, in the case of conception, when I'm talking with a couple about the sacred aspects of conception and really nurturing their sexual relationship in a spiritual way, and honoring the femininity or honoring the masculinity in their partner and like I was talking about, the femininity... feminine energy tends to be empathetic and sensitive, and intuitive, right? And masculine energy tends to be action-driven, right? So that's beautiful too, if we think about things in a different way fundamentally, like they're wired differently. And that's a complete generalization, like there's always grey areas, but if we're talking about generalizations, yeah I think the masculine and feminine balance each other out and that's what brings balance and that's ok and that's good".

Marshall begins her response by including a legitimizing qualifier, positioning herself as someone who consistently reads and studies in order to keep her practice medically legitimate. Next, she highlights what she believes are the "inherent qualities" of men and women that are

“designed to balance each other out”, and how, in order to conceive a strong child, the polarity between the man and woman involved must be strong, emphasized, and honored in the process of conception. She believes in biological determinism in the sense that men and women are “wired differently”, and this causes them to have different energies that are meant to be polarizing, and that healthy couples build on the strength of that polarity.

However, Marshall also believes that there is a right and a wrong way to “do” polarity, and that many people are acting out their masculinity or femininity incorrectly. She follows:

“But I think our culture, we kind of messed up our perception of femininity. We don’t embrace femininity in the same way, we see femininity as looking a certain way and smelling a certain way and making sure no one knows you’re on your period. I think we’re really out of touch with our true femininity, and I think the same thing goes for masculinity. Men are taught not to be emotional, and that’s not... I think all humans, male or female, should be able to express their emotions. I think it’s a skill set of women, but it’s obviously there for men, but our culture kind of stamped that out a bit.”

Marshall holds skepticism about the ways in which masculinity and femininity are “done” in our society, arguing that they do not accurately correlate with our true, innate senses of masculinity and femininity-- they are not bio-authentic. Essentially, Marshall is arguing that patients, in order to be true to themselves and be as healthy as possible, should do gender differently, in a way that more accurately suits their natural differences based on their different wiring.

This finding directly contradicts the conclusions of both Sointu and Brenton & Elliot. Sointu argued that CAM fields encourage their patients to detraditionalize how they do gender. This is true to an extent, although the ideas these practitioners have about innate, biologically determined gender expressions are relatively traditional in terms of how they interpret sexed behaviors. Brenton & Elliot argue that gender expressions are re-traditionalized in CAM fields, and that the practices encourage patients to do traditional gender expressions. My findings indicate that instead of encouraging patients to either “do” or not “do” gender, functional

medicine providers encourage their patients to do gender differently, adjusting their gender expressions to fit with what they believe are authentic, biologically determined gender traits.

Conclusion

The goal of this project was to determine who functional medicine providers want their patients to become. My findings indicate that functional medicine providers want their patients to take active responsibility for themselves and their health problems via introspection and attention to their gender bio-authenticity. Gender bio-authenticity is the lens through which functional medicine providers encourage their patients, particularly their women patients, to interpret and perform their gender expressions. Neither the practitioners whom I interviewed, nor the Institute for Functional Medicine, utilizes the term “gender bio-authenticity”, as it is a descriptive term I have assigned to explain the gender ideologies of the specific participants in my study. Gender bio-authenticity refers to the belief that people have innate, biologically determined gender traits. Gender stereotypes may be influenced by these innate gender traits, however, popular gender stereotypes do not reflect “authentic” understandings of masculinity and femininity, according to my participants.

This finding is sociologically significant because it provides a new way of interpreting gender governance in CAM fields. Two studies that I reviewed, Sointu’s work and Brenton & Elliott’s work, debated whether CAM fields encouraged de-traditionalization of gender expressions within their patients or for their patients to behave in accordance to traditional gender values. My findings indicate that neither is the case, as my participants indicated beliefs about gender that both subvert traditional gendered behaviors and re-affirm gender stereotypes.

What I found functional medicine practitioners were truly concerned with was the expression gender authenticity that, according to them, is innate and biological.

My findings are limited by the fact that my sample size is too small to generalize to the community of functional medicine practitioners or CAM as a whole. The Institute for Functional Medicine did not publish any claims about gender authenticity. If I were to hypothesize as to why, I would assume that the IFM does not want to engage with gender narratives because it is trying to fight its feminized social labelling. As such, the discourse I found from the IFM revolving around responsabilization serves to support my discussion of gender governance.

While I believe my findings are valuable, future research would require a much larger sample size of functional medicine practitioners to confirm them. Though my findings on gendered responsabilization and legitimization are supported by related research on those subjects, there is very little research on gender bio-authenticity in CAM fields for me to place my findings in dialogue with. As such, I would ideally hope to expand this project to include more participants to confirm my findings or make them generalizable to functional medicine practitioners as a whole.

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