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Hidden in Plain Sight: Exploring Men's Use of Complementary and Alternative Medicine

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Abstract

Despite the increased attention given to the relationship between masculinity and health, the analysis of men's use of complementary and alternative medicine (CAM) is relatively underdeveloped compared to studies of female use. Through the thematic synthesis of existing research studies, this paper collates and analyses patterns of, and motivations for, male usage of CAM. We reveal that there are significant levels of male use of CAM which cannot be explained by recourse to general or gendered patterns of health seeking behaviour or health status. Men who use CAM tend to exhibit similar demographic characteristics to female users, but also show patterns of engagement that both reinforce and challenge hegemonic masculinity. The paper suggests that there remains a need to investigate the nuances and complexities of the motivations behind male usage patterns, and interrogate how these intersect with the performance of masculine selves.

Keywords: complementary and alternative medicine, health, masculinity, sociology

Hidden in Plain Sight: Exploring Men's Use of Complementary and Alternative Medicine

Introduction

Complementary and alternative medicine (CAM) has seen a marked increase in popularity since the 1970s and it has been observed that both users and practitioners are more likely to be women. Reflecting this, the gendered nature of CAM use and practice has become a key focus of social scientific research. Such work has demonstrated that CAM can provide a space that allows women to address their health concerns, resist the patriarchal medicalisation of conventional practice, and explore opportunities for empowerment, control, and feminine self-realisation. As such, this body of work suggests a possible affinity between femininities and CAM, the latter providing gender-sensitive health care. Notwithstanding the valuable insights of this work, the research focus to date has served to background the experiences of male users of CAM. This article seeks to redress this imbalance through a thematic synthesis of existing research studies.

Despite the dominance of biomedicine, CAM experienced a groundswell of appeal from the late 1970s, and surveys suggest that this popularity has been sustained and enhanced (Eisenberg et al., 1998; Tindle et al., 2005). CAM is used as a shorthand term to cover a wide array of therapeutic modalities that fall outside the canon of biomedical practice, but vary significantly in the degree to which they contradict conventional medical principles. CAM ranges from complete medical systems such as homeopathy, herbalism and acupuncture, through discrete interventions such as osteopathy and chiropractic, to diagnostic practices such as iridology and reflexology. It also includes spiritual healing, dietary interventions and prayer. As such, use of CAM can involve formal contact with a practitioner, or can be on the basis of self-prescription (Cant, 2009).

Such broad parameters have meant that a variety of definitions is used within research studies, making the calculation of usage rates difficult. Nevertheless, a number of key surveys indicate that around a third of the adult population in the USA and UK have consulted a CAM practitioner (Eisenberg et al., 1998; Harris et al., 2012). These surveys also suggest that users are characterised by a number of socio-demographic features: they are more likely to be female, middle aged and middle class, with higher than average levels of education and disposable income, and a greater likelihood of suffering from a chronic illness. Research has also shown that, with the exception of chiropractic and osteopathy, the majority of practitioners are also women (Flesch, 2007; Scott, 1998; Taylor, 2010).

The fact that the majority of users and practitioners of CAM are women has fostered research to deepen our understanding of this patterning. Such research has suggested that CAM constitutes gender-sensitive, feminist practice, which can facilitate personal transformation and wider social change (Meurk et al., 2013; Nissen, 2011; Scott, 1998). Women's reasons for turning to CAM include: having had negative experiences of both conventional medicine and relationships with biomedical practitioners; the perception that CAM is safer and natural; the desire to boost general health, wellbeing and quality of life, and prevent illness; the perception that CAM is empowering, affording personal control over health and health care; a desire to maximise the chance of a positive health outcome, when biomedicine cannot guarantee one. CAM therefore provides women with an internalised 'power-from-within' (Keshet & Simchai, 2014, p.77), a means to resist dominant biomedical definitions, to assert ownership and self-responsibility over health, and to navigate new forms of self-hood (Brenton & Elliot, 2014; Fries, 2008). For example, Sointu (2006) argues that in a patriarchal social context, CAM provides a milieu in which women can engage in practices of reflexive fulfilment associated with modern selfhood, but which are often otherwise inaccessible to them. However, much of this research focuses on privileged, middle class women in the West and may not speak to the

experiences of other women (Broom et al., 2009; Sen & Chakraborty, 2016; Shih et al., 2008). Nevertheless, it has been suggested that the epistemologies of CAM, with their focus on empathy, subjectivity and interpersonal relations, are closely aligned to modes of thinking historically associated with femininity, which were displaced with the emergence of modern science (Bordo, 2003; Cant & Watts, 2012). This affinity between CAM and feminine needs and aspirations could serve to discourage male engagement (Sointu, 2012). Studies have shown that a positive view about science is correlated with scepticism towards CAM, and that men are more likely to hold such views (Furnham, 2007). Overall, these analyses offer undeniable insight into the context and motivations for use of CAM by women, which can inform the analysis of male use.

Sociological research into health has understandably foregrounded the experiences of women, in recognition of the intersections of medical practice and patriarchal power (Kuhlmann & Annandale, 2012). In contrast, the analysis of masculinity and health is a relatively new but important concern within sociology (Courtenay, 2000; 2011). This work also provides valuable insights for understanding male use of CAM in that it establishes that the relationship between masculinity and health is not straightforward. Masculinity is a complex, changing, and relational entity: hegemonic masculinity – understood as culturally dominant normative practices that legitimate male power – is associated with traits such as rationality, decisiveness, instrumentalism, and an emphasis on phallic heterosexuality; however, it exists, and must be understood, in relation to other subordinated, complicit or marginalised masculinities (Connell, 2005).

Courtenay (2011) demonstrates that certain aspects of hegemonic masculinity are threatening to health. Those very behaviours that serve to endorse ‘maleness’ can be simultaneously damaging to physical and mental well-being. Specifically, men engage in riskier behaviour (smoking, drinking, etc.), hold riskier health beliefs, and are less likely to

engage in health promoting activity or attend for screening. They are generally less likely to seek biomedical help than women. Wang and colleagues' (2013) analysis of primary care in the UK suggested that the crude consultation rate was 32% lower in men than women, which could be understood as an expression of 'virtuous masculinity' (Noone & Stephens, 2008). These generally lower usage patterns could also account for the lower proportion of men who use CAM (Verhoef et al., 2005). Wootton and Sparber (2001) note that whilst women are more likely than men to use CAM, the difference is: 'seldom or only marginally significant and is usually proportional to the gender balance of people seeking all forms of treatment' (p.202). When men do consult biomedical practitioners, research suggests female partners play a significant role in mediating and galvanising relations with doctors (Courtenay, 2011).

This general understanding of the link between masculinity and health is complicated by a number of factors (Robertson, 2007). First, dominant forms of masculinity are historically specific, shaped by class, ethnicity, sexual orientation, education, and geographical location, which intersect with and influence health behaviour (Courtenay, 2011). Second, whilst a number of defining dispositions associated with hegemonic masculinity align with health limiting activity, other aspects, such as an instrumental wish to take control, could be linked to health conferring behaviour. For instance, in Wenger and Oliffe's (2014) study of men's management of cancer, respondents embodied masculine ideals of strength and stoicism post diagnosis, and sought to enhance their physical resilience. Seale and colleagues (2006) showed that male cancer patients' use of the internet focussed on gathering information on treatments, personnel and procedures: by contrast, women tend to seek social and emotional contact and support. Third, the existence of dominant masculinities does not preclude the emergence of new and alternative forms, such as those which might encourage emotional awareness, self-care regimes, and health promoting activity (Nissen, 2017; Sointu, 2012). The acknowledgement of more than one type of masculinity enables a more sophisticated

understanding of health practice and can explain the recourse to both risky and health promoting behaviour. For instance, men who find themselves subordinated or marginalised by hegemonic masculinity may respond either by adopting hazardous hyper-masculine practices (as in the case of gay men who reject safer sex, Knight et al., 2012) or by seeking to perform an alternative but coherent masculinity through responsible engagement with medical advice (as in the case of male infertility, Bell, 2016).

Understanding male use of CAM can be informed through studies that have concentrated on male specific conditions such as erectile dysfunction, prostate cancer and infertility. These studies reveal how hegemonic masculinity is simultaneously compromised through such conditions, but also endorsed and reaffirmed by biomedical practice. Male factor infertility, for instance, is associated with feelings of inferiority, embodied failure and social subordination, and with restricted opportunities for emotional expression (Dolan et al., 2017). In the case of prostate cancer, biomedical interventions often result in emasculating side-effects such as erectile dysfunction, loss of libido and feminised body shape (Chapple & Ziebland, 2002). Navon and Morag (2004) showed that hormonal therapy had an extensive impact on men's relationships with their partners and friends, and compromised their ability to cope and feel hope. Moreover, biomedicine tends to take conventional masculinity as the norm: for instance, through seeking to restore erectile function at the expense of alternative expressions of male sexuality (Potts et al., 2006). This literature serves to illustrate the complex and nuanced responses to health related threats to masculinity. Taken together, the sociological literatures on women's use of CAM, and on masculinity and health, provide a lens through which to analyse existing research on male use of CAM.

Methods

The absence of an overview of male use and experiences of CAM prompted us to undertake a systematic review of existing qualitative and quantitative studies. We used the mode of analysis described by Thomas and Harden (2008) as thematic synthesis. This is a relatively new approach to analysing qualitative data. The method acknowledges that whilst such research is in essence non-generalisable, nevertheless there is value in identifying reoccurring themes, using an inductive approach. This permits translation of ideas across otherwise context specific studies, and allows the researcher to identify generic processes (Schwalbe et al., 2000) such as would inform gendered patterns of CAM use.

A review of existing research studies on male use of CAM was undertaken to collate and examine usage patterns, and to elicit explanations for male use when it occurred. Three widely used databases (Web of Science; ASSIA; Science Direct) were searched using the following terms: men; male; masculinity; gender; complementary medicine; and alternative medicine. Given the expansion of relevant studies from the turn of the twenty first century and the concurrent emergence of sociological interest in hegemonic masculinity, the search ran from 2000 to 2017. It was limited to articles in English, but was not limited by country of origin. Articles pertaining to use by women only and children were also excluded. Duplicate articles were removed and an abstract scan of 5541 results was undertaken (Web of Science, 1142; ASSIA, 2247; Science Direct, 2152) to identify articles that discussed men's use of CAM. This review yielded a sample of seventy-one articles. From this sample, two subsets were derived. The first comprised fifty articles that detailed levels of male and female use, but provided no detailed examination or explanation of the patterns. These were all reviewed, but for the purposes of this article, we discuss only the thirty-one most recent (2006 – 2017, Table 1), as they were representative of the data set as a whole. The second sub-set comprised twenty-one articles (2000-2017) that offered more detailed accounts of male experience of using CAM.

Two of these were subsequently excluded as they were meta-analyses, leaving a sample of nineteen (Table 2).

The articles were independently read by two researchers to identify and record key patterns and concepts. The themes were then compared and discussed, to inform a second reading. This iterative process enabled the researchers to recognise concepts and themes across studies even when they were framed differently. The review yielded information about levels of use, sample size, variables associated with use (e.g. socio-demographic characteristics, health conditions, types of therapy), and the motivations of the users.

Findings

Gender and CAM Use

The first subset of articles broadly corroborated the view that women use CAM more extensively than men, and a number of studies revealed differences between female and male use in excess of 15% (Akyol et al., 2011; Chang et al., 2011; Garland et al., 2013; Kalaaji et al., 2012; Kav, 2009; Nissen et al., 2014; Skovgaard et al., 2013). However, deeper interrogation revealed a picture complicated by a number of factors.

Please insert Table 1 about here

First, there are methodological issues in that: the studies we reviewed varied significantly in how they operationalised CAM; the substantive focus of the research differed in terms of illness categories, therapeutic modalities and countries in which use was investigated. This made direct comparison between studies difficult. Moreover, many studies had samples skewed towards one gender or the other (e.g. Sharpe et al., 2016). Additionally,

a number of studies emphasised gender difference in use but either did not provide detailed data to support this claim, or gave figures for female use only (Bensoussan et al., 2006; Cramer et al., 2015).

Second, there was little recognition in the studies that we reviewed, that lower use by men may be a reflection of their general health seeking behaviour patterns, rather than a function of their relationship to CAM. For instance, Steinsbekk and colleagues (2007), in their survey of health service use in Norway, showed that 68.5% of female respondents had consulted their biomedical General Practitioner (GP) compared with 58.6% of male respondents (a 9.9% difference): however, female use of CAM exceeded male use by only 3.1%. Of the studies where details were given: around a third reported usage rates by women that exceeded male use by 15% or more; a further sixth reported patterns that matched gender differences in GP use (around 10%). The remaining half recorded gender differences that were less than those found in relation to GP use, and were not always statistically significant.

Third, the analysis revealed substantial male use of CAM, although this was left largely un-interrogated. For instance, Agnoletto and colleagues (2006), in their study of HIV infected subjects, highlight that CAM use was significantly more common amongst women, but their data also showed that a large percentage of the male sample drew on a broad range of healing modalities (67% of women and 56% of men). Similarly, Kalaaji and colleagues (2012) found that use of chiropractic showed no gender differences and again this was unexplored.

Fourth, even when substantial levels of male use were reported, there was a tendency to emphasise the putative connection between CAM and women. For instance, Ben-Arye and colleagues (2009) note that 39.4% of men in their sample used CAM compared to 46.4% of women, and then go on to focus their discussion entirely on female use. Moreover, marginally greater use of CAM by women was emphasised (e.g. Lökk & Nilsson, 2010). For instance,

one study (Sharpe et al., 2016) reported ‘that use of one or more CAM modalities for arthritis was not statistically significantly associated with age group, gender...’(p. 40), but then concluded that, ‘As in other CAM studies, women ... were more likely to be users’ (p. 42). The authors draw this conclusion because they found that women were more likely to use multiple modalities than men.

Fifth, notwithstanding the general association between women and CAM use, some studies reported no correlation by gender (Braun & Cohen, 2011; Konvicka et al., 2008). Others reported higher use by men (Dhalla et al., 2006; Kim et al., 2011; Manya et al., 2012; Unsal & Gozum, 2010) with no clear alignment to specific health conditions. Steinsbekk and colleagues (2007) noted that, whilst more women simultaneously consult biomedical and CAM practitioners, there was a stronger propensity for men to consult *only* CAM practitioners. Greater male use was, however, rarely examined in detail, and was often disregarded. For instance, Unsal and Gozum (2010) report that ‘complementary and alternative medicine users and non-users were not significantly different in most socio-demographic characteristics including ... gender...’ (p.1129), despite their data recording ten per cent higher usage by men. Similarly, Manya and colleagues (2012) did not discuss the greater male use that their studies revealed.

Understanding Male Use of CAM

Our review of the first sub-set of articles revealed significant levels of male use of CAM. The second subset included both quantitative and qualitative research and accordingly provided some insight into men’s experience and motivations in relation to CAM with a predominant focus on male-specific conditions such as prostate disorders including cancer, infertility and erectile dysfunction. High levels of usage are also reported by HIV infected men. The rates of usage vary across studies, with median figures suggesting about a third of men use

CAM for prostate cancer (Boon et al., 2003b; Chan et al., 2005). These rates are higher than the overall figure for male use in the general population, and are similar to female use of CAM for breast cancer (Diefenbach et al., 2003). The use of CAM for HIV/AIDS is much higher than general usage by both men and women, with studies suggesting consultation rates that exceed 60% (Bormann et al., 2009; Dhalla et al., 2006).

Please insert Table 2 about here

Male use of CAM is associated with similar socio-demographic and health variables to female use. Users tend to be younger, better educated, have higher incomes, have more functional disability, and experience more severe illness, than non-users. Some studies reveal further correlations between CAM use and religion and ethnicity (Kaufman & Gregory, 2007; Klafke et al., 2012).

An emphasis on using CAM to take instrumental control of one's health was both common within, and unique to, the studies of male use (e.g. Eng et al., 2003; Hall et al., 2003). For instance, Boon and colleagues (2003a) found that respondents who were not eligible for conventional treatment for prostate cancer (due to age or comorbidity), and had been advised to engage in 'watchful waiting', were drawn to CAM in order to take control of their situation. Similarly, Diefenbach and colleagues (2003) found greater use of CAM amongst men in this category, and suggested that: 'watchful waiting may really be 'watchful doing' whereby patients self-treat with CAM' (p.168).

In the study by Brenton and Elliott (2014), that compared male and female decision making regarding CAM use, men uniquely deployed narratives of responsible choice-making, rationality (over emotional decision-making) and science. The men in their sample were keen

to describe their independence and stoicism. Similarly, Sointu's (2006) qualitative study suggested that men's use of CAM was informed by traditionally masculine concerns, albeit in modified forms: the men she interviewed drew on masculine scripts such as an emphasis on achievement, physicality and instrumentalism, to explain their use of CAM.

Klafke and colleagues' (Klafke et al., 2014a; 2014b) study of men's use of CAM for all cancer types showed the importance of coping and control. They identified three aspects to the coping strategies deployed by the men in the sample: problem-focussed coping in which CAM was used to bolster bodily health; emotion-focussed coping centred on managing psychological distress; meaning-focussed coping where CAM provided a resource for navigating the existential consequences of life-threatening illness. Taken together, these strategies represented 'active coping behaviour... and, in particular, the opportunity to overcome passivity and resignation...' (p. 1240), two dispositions which are arguably inimical to hegemonic masculinity.

The issue of control is a central motif in studies of men with HIV (Hsiao et al., 2003; Kaufman & Gregory, 2007; McDonald & Slavin, 2010). Users described how CAM provided a resource through which to redefine their illness and forge new identities. For example, Foote-Ardah (2003) showed how CAM helped alleviate some of the detrimental side effects of AIDS medication and provided new ways of controlling HIV. More than this, CAM provided a means of exerting independence and making flexible choices in a context where the medical profession required adherence to strict regimens: 'maintaining personal control over treatments is important to people with HIV ... the very act of having a choice ... enhances personal control and reduces medical dependence' (pp. 492-3). Pawluch and colleagues' (2000) respondents, the majority of which were men, articulated the importance of control through seeing health as their individual responsibility. They used CAM to enhance their longevity and wellbeing, and as an alternative to, or to mitigate the side-effects of, conventional treatment. Moreover, their

respondents also felt that conventional medication for HIV was stigmatising: CAM was therefore used to manage HIV infection and thereby delay the need to turn to biomedicine and the associated changes to one's master status. The stigma associated with medical treatment for mental health issues was also described as a factor in the decision to use CAM by HIV infected men with depression (Bormann et al., 2009).

People living with HIV/AIDS (PLWHA) are often exceptionally knowledgeable about, and proactive in relation to, managing their condition. In this context, the use of CAM can also be understood as a form of activism and resistance to biomedicine. McDonald and Slavin (2010) found that their respondents rejected the dehumanising, militaristic metaphors commonly found in conventional medical discourse, preferring to frame their experience in terms of the destigmatising, holistic health language of CAM. Similarly, Pawluch and colleagues (2000) found that some of their respondents reported significant distrust towards biomedicine, finding it sexist, racist and homophobic. In contrast: '... complementary therapies represented a way to make a statement about the unresponsiveness and oppression of Western medicine' (p. 261). They go on to conclude that CAM use amongst socially marginalised constituencies, such as gay men living with HIV/AIDS, should be understood in the context of the deep-seated and widespread prejudices that shape their everyday lives.

The turn to CAM is generally understood as a response to the adverse effects of conventional medicine. In the case of prostate cancer, there is evidence that men are concerned about impotence and incontinence, and see CAM as offering a less aggressive form of intervention. In Boon and colleagues' study (2003a), one respondent described their rationale as follows: 'I decided that the alternative of going under the knife and being either impotent or incontinent or all the other side-effects that you can have, this [CAM] is a better chance to try and get myself under control again' (p. 475). Here we see threats to masculinity being countered by the reassertion of control, enabled by CAM. It is interesting to note that the rates

of usage of CAM were double for those men on hormonal treatment (Boon et al., 2003b, Wilkinson et al., 2003), a biomedical intervention which can induce emasculating side-effects.

In a study of erectile dysfunction in Mexican men, Wentzell and Salmerón (2009) observe a further dynamic associated with the choice of CAM treatments. Conventional medicine, with its emphasis on restoring erectile function, was often deemed to be inappropriate as it failed to take sufficient cognisance of men's age and changing disposition towards sexuality. In contrast, alternative treatments afforded a holistic and context sensitive response: '... participants who understood themselves to be older saw graceful acceptance of diminished sexual function as a responsible and healthful act suitable to their life phase. Thus, rather than focussing on penetration and seeking means to achieve it in the face of erectile difficulty, participants sought to perform sexual and health behaviours that were respectably appropriate to their position in life' (p. 1764). This reveals the potentiality for CAM to provide health care that is sensitive to the nuances of differential masculinities.

It is widely reported that friends and relatives play a part in the decisions taken by men to try CAM (Brenton & Elliott, 2014; Eng et al., 2003; Kaufman & Gregory, 2007; Klafke et al., 2012). In contrast, Öhlén and colleagues (2006) argued that the men in their study downplayed the influence of their significant others. They explain this reluctance as stemming from traditional masculine role attributes such as decisiveness. The support given by women to their male partners may also mean that they do not need to seek help from CAM practitioners: 'it is possible that social support from wives and partners buffers distress of men with prostate cancer to a much larger extent than distress is buffered by partners of patients with breast cancer' (Diefenbach et al., 2003, p.169). It is also the case that men used the internet more readily to locate information (Boon et al., 2003a; Eng et al., 2003) and the studies also established that men belonging to support groups were also more likely to use CAM (Boon et al., 2003b).

Klafke and colleagues (2014b) provide a more nuanced account of the role of significant others and how this intersects with the performance of masculinity. Men were more likely to seek and follow the advice of their female significant others in relation to CAM practices when these were specifically aimed at improving bodily health, for example the use of herbal medicine. However, when men turned to CAM for emotional support, they would tend to do so independently and privately. The authors make the case that in both scenarios masculine identities are reinforced. In the former, men were prepared to accept advice and defer to their partners as the context mirrored the domestic sphere where women tend to make decisions about food and health maintenance. In contrast, keeping emotion-focussed CAM use as a private practice allowed the men to manage their feelings of fragility and anxiety, while maintaining a public identity premised on strength, autonomy and control.

Discussion

The systematic review of existing research revealed that whilst women generally use CAM more extensively than men, male use is far from insignificant. Indeed, considering the fact that women use health services more readily than men, the differences in CAM use by gender are often smaller than might be expected. Given that men tend to use health care services more conservatively, the findings of similar usage patterns by men and women, and of greater male use of CAM in some surveys, is worthy of attention. Significant male use has been left relatively unexplored and greater emphasis has been given to explaining the attraction of CAM to women, even when differences are small or negligible.

The survey based research showed that male users have broadly parallel socio-demographics to female users, and are similarly concerned about the side-effects of conventional treatments. Overall, the review did not reveal strong associations between male use and particular therapeutic modalities beyond some preference for physical treatments such

as manipulative therapies or the ingestion of herbal and dietary supplements. These associations are worthy of further study. The finding that men are more likely than women to use CAM exclusively also warrants further investigation.

In the same way that many studies of women users of CAM focus on conditions such as breast cancer and the menopause, the studies in the second subset were characterised by a concern with male-specific health conditions. While it is important to be cognisant that the findings of this thematic synthesis will necessarily reflect the methodological choices of the studies we reviewed, nevertheless a number of potential themes for further study were revealed. Specifically, there is some evidence to suggest that male users' motivations, and their overall dispositions towards CAM, intersect with the performance of hegemonic, subordinate and complicit masculinities.

For instance, a number of aspects of men's use of CAM arguably align with hegemonic masculinity: the desire for instrumental control; a focus on problem-solving; the above noted preference for mechanical modalities; a greater likelihood of exclusive use of CAM. Together, these perhaps reflect characteristics of decisiveness and instrumental rationality, and contrast with evidence that the emotional and relationship dimensions of CAM have a stronger appeal for women. Moreover, when men did use CAM for emotionally-driven reasons, they were less inclined to share this with their significant others, enabling them to preserve the integrity of their public performance of masculinity.

The review revealed other instances in which CAM use contradicted hegemonic masculinity. For instance, in Connell's (2005) terminology, gay masculinity is understood to be situated in a position of subordination to hegemonic masculinity. Non-heterosexual men with HIV/AIDS are some of the highest users of CAM, and whilst this might be a reflection of their knowledgeable ability, and the chronic nature of the disease, it is plausible that CAM provides

a space where the pervasive power of stigmatising, heteronormative biomedicine can be resisted. CAM use also seems to be associated with those conditions where it is harder to comply with hegemonic masculinity. One instance of this is prostate cancer, and especially in the case of men who have been prescribed hormonal therapy. Navon and Morag (2003) describe powerfully the disruption caused by this therapy – side-effects include loss of libido and potency, the feminisation of the body, and mood disturbances. The use of CAM by men with prostate cancer is twice as prevalent when this treatment regimen is prescribed. Potentially this is because hormone therapy radically compromises the ability to perform sexually or draw effectively on conventional masculine scripts to inform a sense of self. CAM therapies with their focus on holism and dialogue can arguably provide a space to explore alternative conceptualisations of gender identity, self and sexuality. This hypothesis finds some corroboration in the studies of CAM use for erectile dysfunction.

We acknowledge that the desire for control and resistance is also characteristic of women's use of CAM. However, the review suggests that there may be differences in the way that control and resistance are imagined and performed, reflecting wider, gendered configurations of power. In this context, women's use of CAM has been helpfully understood in terms of a generalised disempowerment rooted in patriarchy; this review suggests that male use, in contrast, may be in response to specific, illness-related disempowerments.

Male use of CAM is an area ripe for further research. There is a need to investigate the nuances and complexities of the motivations behind male usage patterns, and interrogate how these intersect with the performance of masculine selves. Future research into male use of CAM would benefit from consistency within the field in terms of the operationalisation of CAM, a greater emphasis on detailed qualitative studies, and a more sophisticated appreciation of the interconnections between sexuality, ethnicity, age, morbidity and specific therapeutic modality.

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