HIGHLY EDUCATED AND PROFESSIONAL, MIDDLE CLASS WOMEN WITH REPRODUCTIVE HEALTH PROBLEMS BETWEEN BIOMEDICINE AND COMPLEMENTARY AND ALTERNATIVE MEDICINE: A CASE STUDY IN TÜRKİYE

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submitted by **TUĞBA ÖZCAN** in partial fulfillment of the requirements for the degree of **Doctor of Philosophy in Sociology, the Graduate School of Social Sciences of Middle East Technical University** by,

Prof. Dr. Sadettin KİRAZCI
Dean
Graduate School of Social Sciences _____

Prof. Dr. Ayşe GÜNDÜZ-HOŞGÖR
Head of Department
Department of Sociology _____

Prof. Dr. Ayşe GÜNDÜZ-HOŞGÖR
Supervisor
Department of Sociology _____

Examining Committee Members:

Prof. Dr. Mustafa ŞEN (Head of the Examining Committee)
Middle East Technical University
Department of Sociology _____

Prof. Dr. Ayşe GÜNDÜZ-HOŞGÖR (Supervisor)
Middle East Technical University
Department of Sociology _____

Assoc. Prof. Dr. İlknur YÜKSEL-KAPTANOĞLU
Hacettepe University
Department of Demography _____

Assoc. Prof. Dr. Çağatay TOPAL
Middle East Technical University
Department of Sociology _____

Assoc. Prof. Dr. Kurtuluş CENGİZ
Ege University
Department of Sociology _____

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last Name: Tuğba ÖZCAN

Signature:

ABSTRACT

HIGHLY EDUCATED AND PROFESSIONAL, MIDDLE CLASS WOMEN WITH REPRODUCTIVE HEALTH PROBLEMS BETWEEN BIOMEDICINE AND COMPLEMENTARY AND ALTERNATIVE MEDICINE: A CASE STUDY IN TÜRKİYE

ÖZCAN, Tuğba

Ph.D., The Department of Sociology

Supervisor: Prof. Dr. Ayşe GÜNDÜZ HOŞGÖR

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This dissertation explores the use of alternative and traditional medicine for reproductive health among highly educated, professional, middle-class women in Türkiye. The aim of this study is to understand why women turn to traditional and alternative medical methods despite having access to biomedical methods, and to understand what these practices offer in the physical, psychological, and social realms. The significance of this dissertation lies in its critical examination of historical and contemporary approaches to women's reproductive health, adopting a radical feminist perspective that addresses the often overlooked aspects of women's health. The study seeks to rethink the dominant narratives by challenging development policies that view women's reproductive health as a tool for population control in developing countries, as well as the liberal, 'choice-focused' model framed within a 'rights' discourse. The research is based on a qualitative study involving in-depth interviews with 18 women from different cities of Türkiye and participant observation methods. The findings reveal that women's preference for traditional medical practices stems from dissatisfaction in the modern healthcare system, the lack of results from prolonged treatments, and the presence of sexist attitudes in

doctor-patient relationships. The study emphasizes that addressing women's reproductive health issues not only in biological terms but also in psychological and social dimensions plays a crucial role. This research contributes new and significant insights into women's reproductive health and the use of TCAM in Türkiye, opening up discussions on social relationships, women's solidarity, collective consciousness, and embodiment of women body.

Keywords: women's reproductive health, biomedicine, traditional and alternative medicine, biopsychosocial medicine, embodiment

ÖZ

BİYOTIP VE TAMAMLAYICI VE ALTERNATİF TIP ARASINDA ÜREME SAĞLIĞI SORUNLARI OLAN, EĞİTİMLİ VE PROFESYONEL, ORTA SINIF KADINLAR: TÜRKİYE'DE BİR VAKA ÇALIŞMASI

ÖZCAN, Tuğba

Doktora, Sosyoloji Bölümü

Tez Yöneticisi: Prof. Dr. Ayşe GÜNDÜZ HOŞGÖR

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Bu tez, Türkiye'deki yüksek eğitimli, profesyonel, orta sınıf kadınların üreme sağlığına yönelik alternatif ve geleneksel tıp kullanımını incelemektedir. Çalışmanın amacı, biyomedikal yöntemlere erişim imkânı olmasına rağmen kadınların neden geleneksel ve alternatif tıp yöntemlerine yöneldiğini ve bu uygulamaların bedensel, psikolojik ve sosyal alanlarda neler sunduğunu anlamaktır. Tezin önemi, kadınların üreme sağlığına dair tarihsel ve güncel yaklaşımları eleştirel bir perspektiften ele alarak, genellikle göz ardı edilmiş olan kadın üreme sağlığına radikal feminist bir bakış açısıyla yaklaşmasıdır. Kadın üreme sağlığını özellikle gelişmekte olan ülkelerde nüfus kontrolü için bir araç olarak gören kalkınma politikalarını ve 'hak'anlatısı çerçevesindeki liberal, 'tercih odaklı' modeli sorgulayarak yeniden düşünmeyi amaçlamaktadır. Araştırma, Türkiye'nin farklı şehirlerinden 18 kadınla yapılan derinlemesine görüşmeler ve katılımcı gözlem yöntemlerine dayanan nitel bir çalışma ile gerçekleştirilmiştir. Bulgular, kadınların geleneksel tıp yöntemlerini tercih etmelerinin temelinde modern sağlık sistemine duyulan güvensizlik, uzun süren tedavi süreçlerinden sonuç alamama ve doktor-hasta ilişkisindeki cinsiyetçi yaklaşımların yer aldığını göstermektedir. Kadın üreme sağlığı sorunlarının yalnızca

biyolojik değil, aynı zamanda psikolojik ve sosyal boyutlarıyla ele alınmasının önemi üzerinedir. Bu çalışma, Türkiye'de kadınların üreme sağlığı temelli, geleneksel ve alternatif tıp kullanımı hakkında önemli ve yeni bulgular sunarak; sosyal ilişkiler, kadın dayanışması, kolektif bilinç ve kadın bedenlenmesi (embodiment) üzerine yeni tartışmalar açmıştır.

Anahtar Kelimeler: kadın üreme sağlığı, biyomedikal, geleneksel ve alternatif tıp, biyopsikososyal tıp, kadın bedenlenmesi (embodiment)

To my grandmothers Sultan Yılmaz and Kezban Özcan,

And to my dear mom, Emine Özcan

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This dissertation is a modest effort to offer a perspective on women’s reproductive and menstrual health that diverges from mainstream narratives. I hope I have done justice to the stories shared by the women I interviewed.I am deeply grateful to all the women who contributed to this research through their stories.

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LIST OF ABBREVIATIONS

ACEs : Adverse Childhood Experiences
AHHA : The American Holistic Health Association
AMS : Alternative and Medical Systems
BBT : Biologically Based Therapies
BPS : Biopsychosocial
CAM : Complementary and Alternative Medicine
ET : Energy Therapies
FM : Family Medicine
GSS : General Health Insurance (Genel Sağlık Sigortası)
HMPs : Holistic Movement Practices
http : Health Transformation Program
IAEK : Human Research Ethics Committee (İnsan Araştırmaları Etik Kurulu)
IASP : International Association for the Study of Pain
IBS : Irritable Bowel Syndrome
ICD : International Classification of Diseases
ICD-10 : The International Classification of Diseases, 10th Edition
ICF : International Classification of Functioning
ICPD : International Conference on Population and Development
IFC : International Finance Corporation
KVKK : The Law on the Protection of Personal Data
MAXQDA : Qualitative Data Analysis Software
MBI : Mind-Body Interventions
MD : Medical Doctor
MH Day : Menstrual Hygiene Day
MHM : Menstrual Hygiene Management
NCCIH : The National Center for Complementary and Integrative Health

OCCAM : Oxford Case Complexity Assessment Measure

PCOS : Polycystic Ovary Syndrome

PCI : Patient-Centered Interviewing

PD : Primary Dysmenorrhea

PMS : Premenstrual Syndrome

PMDD : Premenstrual Dysphoric Disorder

TCAM : Traditional, Complementary, and Alternative Medicine

TCM : Traditional Chinese Medicine

TMA : Turkish Medical Association

TM : Traditional Medicine

UNFPA : United Nations Population Fund

UNICEF : United Nations International Children's Emergency Fund

WASH : Water, Sanitation, and Hygiene

WB : World Bank

WHO : World Health Organization

WID : Women in Development

WONCA : World Family Medicine Association

GETAT : Integrative Medicine, Complementary, Alternative Medicine Application Units

CHAPTER 1

INTRODUCTION

Many women of different ages are facing reproductive health related problems. Women's body and reproductive health issues have been controversial topics in the history of biomedicine and are also worth researching from a sociological perspective. According to the World Health Organization (WHO) global report (2019) the use of Traditional, Complementary, and Alternative Medicine (TCAM)[1] has increased in Western countries in recent decades (Mortada, 2024; Eisenberg et al., 1993).

Women are more likely to consult TCAM healthcare methods than men (Eardley et al., 2012; Rayner et al., 2011; Tindle et al., 2005; Verhoef et al., 2005; Ernst & White 2000; Beal, 1998; Sharma 1995). Furthermore, women's reproductive health is a key example of the growing trend toward traditional medicine and the adoption of newly emerging alternative therapies (Rayner et al., 2011; Beal, 1998). What can women who have experienced reproductive health problems and prefer TCAM methods and alternative healing practices in their treatments tell us about the biomedical and biopsychosocial (BPS)[2] understanding of health and illness?

In this thesis, I argue that the phenomenon of women's reproductive health, specifically the menstrual-related conditions provides a case through which the

1 Chauhan and Agarval describe traditional systems of medicine as such: "Traditional systems of medicine … have been in practice in Southeast Asia since time immemorial. These systems, which originated in India (Ayurveda), China [herbal medicine, acupuncture, massage (tui na), exercise (qigong)] and Greece Persia (Unani system) are still prevalent worldwide, along with other forms, including Tibetan medicine (a synthesis of Ayurveda, Chinese, Persian and Greek systems), homeopathy, magnetic therapy and others. It is estimated that up to 80% of the population in the developing world and nearly 20% in the western world use traditional medicine " (2015, p.206).

2 Biopsychosocial is a term used by George Engel (1977) to identify his medical model, in this thesis I will use biopsychosocial and its abbrevation BPS interchangebly.

broader structures[3] of gendered nature of medicine, can be observed in the preferences of women's health seeking behavior between biomedical and holistic health models.

1.1. The Purpose of the Study and Navigating the Intersection of Personal and Academic Inquiry

My personal health journey and the persistent questions I had in the field of gynecology led me to choose this topic for my academic study. From the age of 16 to 33, I consulted numerous gynecologists for menstrual-related health problems. In the early years, I experienced heavy menstrual pains without understanding the cause. Following medical advice, I adhered to a 4-5 year regimen of the pain reliever Majesik. As I entered my 20s, I was diagnosed with Polycystic Ovary Syndrome (PCOS) and Premenstrual Syndrome (PMS), marking the beginning of a long struggle. I experienced constant fatigue, abdominal pain, backaches, and brain fog—symptoms I only fully recognized later. This exhaustion gradually took over my life, affecting my daily routine and mental well-being. Despite following medical advice, including a five-year course of birth control pills, my symptoms persisted and worsened. I started losing hair, developed adult acne, and felt increasingly low.

Despite reassurances from multiple doctors that my symptoms were 'normal' for some women, my instincts told me something was wrong. Many gynecologists advised that severe pain and PMS would resolve with marriage or childbirth (from my personal encounters with doctors). It is debatable how medically sound the advice of marriage or childbirth as a remedy for pain truly is, as these were superficial recommendations made without any medical explanation to support them. Therefore I continued searching for answers. Along with PCOS, I eventually

3 At this point, it is important to emphasize that women's reproductive health and its relationship with the use of TCAM cannot be separated from the neoliberal transformation of healthcare, both in Türkiye and globally. However, the focus of this thesis is not an analysis of the neoliberal restructuring of health systems. Some studies have drawn attention to the neoliberal reorganization of healthcare in relation to the female body. These works primarily address the medicalization of the female body and the governance of maternal bodies, situated between biomedical power and neoliberal healthcare systems. For a more detailed discussion on this topic, see Alkan, H., Dayı, A., Topçu, S., & Yarar, B. (2023). The politics of the female body in contemporary Turkey: Reproduction, maternity, sexuality. I.B. Tauris

discovered that I had high estrogen, IBS, and various food intolerances. These findings were crucial in understanding my health and fueled my desire to study this topic academically.

Chronic allergies and fatigue, spring allergies, sleep disorder, irregular menstruation[4], and severe menstrual pain led me to consult numerous doctors and take various medications. However, instead of alleviating my symptoms, the medications often worsened them, leaving me feeling hopeless. Despite consulting practitioners of conventional biomedicine across different hospitals in Türkiye[5], I found no lasting relief. Painkillers and birth control pills offered temporary solutions but failed to address the root causes of my health issues, sometimes even causing additional harm.

In October 2016, upon a friend's recommendation, I consulted a doctor who combined modern biomedicine with Traditional Chinese Medicine (TCM). Dr. Elif Selek, a pathology specialist and complementary practitioner, finally understood my condition. Under her guidance, I began a holistic treatment process that significantly changed my life. During 2017-2018, I completely altered my eating habits and lifestyle. Although the transition was challenging, the natural treatment worked for me, and I committed myself to healing, continuing to explore and try other TCAM methods. I can say that I made it my mission to heal.[6] I also stopped using chemical pills for my hormonal issues altogether.

During this period, my doctoral research question began to develop alongside my recovery journey. At this point, I would like to share examples from my field research interviews, highlighting my interlocutors' accounts about the severity of

[4] Menstruation is a regular and recurring process that occurs in a woman's life from the onset of puberty, typically around 12 to 13 years old, until menopause, which generally occurs around the age of 50.

[5] In 2021, Turkey changed its spelling to Türkiye via the UN. See: https://en.wikipedia.org/wiki/Name_of_ Turkey#:~: text=Turkey%20adopted%20its%20 official%20name,changed%20its%20spelling%20to%20T%C3%BCrkiye

[6] My periods were still irregular during 2017-2018 and I haven't menstruated for 9 months, which is called as secondary amenorrhea. It was a difficult phase for my life and all my focus was on recovery and searching the reasons and solutions for my health problems from a holistic view and looking for ways to heal.

their symptoms and the long duration it took to receive a diagnosis. Their stories further confirmed the importance of exploring women's health issues, which has become central to my academic research:

> I was taking 1-2 Majezik, sometimes 3, throughout the entire period. These pains kept increasing. I would go to the doctor, saying it hurts a lot. They would say, "You will take a painkiller, it is normal."[7] Nüzhet, age 39

> I always had pains. I always had such heavy, painful periods. I mean, I was constantly suffering from pain. My doctor said, "Cahide, this will not kill you, but it will make you crawl (groveling - meaning suffer)". This was four days before my last surgery, which was going to be my third endometriosis surgery. Of course, I had been dealing with this for years—we're talking about 10-15 years. The pain and other symptoms started with my first menstrual period and continued thereafter.[8] Cahide, age 43

As illustrated by the experiences of my interviewees[9] above, Nüzhet and Cahide, the persistence of pain in women's reproductive health is often normalized, with their suffering frequently regarded as an expected part of their condition. Both Nüzhet and Cahide recount enduring significant pain, with medical professionals dismissing their symptoms as normal and suggesting that painkillers are the only solution.

Nüzhet, at 39, describes escalating pain despite taking medication, while Cahide, at 43, reflects on a decade or more of debilitating menstrual pain and multiple surgeries for endometriosis, emphasizing that her pain began with her first menstrual period. These accounts highlight critical issues in women's reproductive health: the normalization of chronic pain[10], the acceptance of severe suffering as part of the condition, and the often prolonged and ineffective search for a proper diagnosis and

[7] The Turkish originale: Tüm regl dönemi boyunca günde 1-2 Majezik, bazen 3 tane alıyordum. Bu ağrılar sürekli artıyordu. Doktora giderdim, çok ağrıyor derdim. Onlar da "Ağrı kesici alacaksın, bu normal" derlerdi.

[8] The Turkish originale: Hep ağrılarım vardı. Her zaman çok ağır, sancılı regl dönemlerim olurdu. Yani, sürekli acı çekiyordum. Doktorum bana, "Cahide, bu seni öldürmez ama süründürür" dedi. Bu, üçüncü endometriozis ameliyatımdan dört gün önceydi. Tabii, bununla yıllardır uğraşıyordum—bahsettiğimiz 10-15 yıllık bir süreç. Ağrılar ve diğer semptomlar, ilk regl dönemimle başladı ve o zamandan beri devam etti.

[9] In the Chapter 2.2.5, I will present the interlocutors in detail.

[10] Women's pain is often underestimated as being termed as 'normal'as I will discuss in detail in Chapter 5.1.

treatment. These realities, though rarely discussed, warrant serious consideration in my opinion.

Modern science has not yet fully elucidated the underlying causes of the various symptoms associated with the menstrual cycle (Bancraft, 1995; Richardson, 1995; Fisher et al., 2016). This uncertainty persists despite Hippocrates' early recognition of the challenges women face due to reproductive health issues (Richardson, 1995). Observing the limitations of conventional biomedicine in addressing women's reproductive health issues, such as hormonal imbalances and amenorrhoea, inspired me to seek alternative solutions for my own condition. This pursuit led me to explore diverse approaches to illness management.

Throughout 2017 and 2018, I focused on restoring my body's health by experimenting with and applying various methods. By 2019, my treatment had significantly improved my health: my periods returned, the poly-cystic ovaries were gone, and the intense abdominal pain subsided. This transformation made me realize that there are actual solutions beyond the repeated recommendations of 'marriage', 'childbirth' and pain-killers from doctors. I discovered that alternatives to painkillers do exist. I began to wonder how many women, like me, had waited for years at doctors' doors, believing their pain was unsolvable, and continued to suffer. Reflecting on my own experiences and the broader challenges faced by many women in similar situations, I felt a strong need to delve deeper into the complexities of women's reproductive organs and menstrual health. This personal journey of healing not only fueled my curiosity but also guided my research focus. As a result, I have dedicated my efforts to understanding and addressing the full spectrum of women's reproductive health including menstrual health issues, hormonal imbalances, menstrual irregularities, vaginal conditions, dysmenorrhea, and endometriosis. My research centers on how women experience and manage these conditions, aiming to uncover insights that can lead to more effective and holistic approaches to women's health.

Based on my experiences and practices during my healing journey, I can confidently say that I benefited from many TCAM methods. I sought treatment from various

TCAM practitioners, including those specializing in Chinese and Japanese acupuncture, ozone therapy, cupping (*hacamat*), leech therapy (*sülük*), osteopathy, magnet therapy, herbal medicine, music therapy, and Qi Gong. Additionally, I immersed myself in a wealth of resources like reading books, watching videos, attending seminars, and taking courses focused on body and mind wellness. I also received training in areas such as 'Women's Healing Arts,' reflexology, yoga, meditation, and Ayurveda. In my experience, these therapies and complementary treatments played a crucial role in my recovery. However, I chose not to explore certain alternative healing practices that I came across frequently, such as Reiki, Access Bars, *Healy* Energy Healing, biofeedback, and homeopathy. My hesitation stemmed from a lack of meaningful explanation of the underlying principles of these methods and concerns about the reliability of the practitioners offering them.

Through my fieldwork, I observed women's experiences with a variety of alternative therapies and witnessed that some of these methods can pose risks to women's well-being, which was unexpected at the beginning of my research. This realization made me be more cautious in selecting the methods I applied to myself. It is important to emphasize that some alternative therapies can have adverse effects on the body, mind, and psychological health. During my search for healing, I encountered some methods whose reliability I initially questioned but decided to try to understand their effects on me. For example, I experienced two alternative therapy techniques: Family Constellation Therapy[11] and Quantum Healing Hypnosis Technique[12]. After these sessions, I noticed that they left me feeling psychologically drained and physically depleted for about two weeks. Based on my experience, I concluded that therapies targeting the subconscious negatively affected my well-being and could potentially have adverse effects overall.

11 Family constellations is a therapeutic approach designed to help reveal the hidden dynamics in a family or relationship in order to address any stressors impacting these relationships and heal them. For details see https://www.goodtherapy.org/learn-about-therapy/types/family-constellations

12 Quantum Healing Hypnosis Technique℠ (QHHT®) enables individuals to connect with a deeper aspect of themselves, often referred to as the Higher Self or Super Conscious, which is believed to possess all the answers. Dolores Cannon, a pioneer in hypnosis and regression therapy, is renowned for her work in exploring the hidden depths of the human mind, offering insights that challenge conventional views on reality. Through this technique, clients can gain a clearer understanding of their circumstances and facilitate personal transformation. Quantum Healing Hypnosis Technique. (n.d.). Retrieved from https://www.qhhtofficial.com/

From the ideation stage of my thesis to the field research process, I have undergone a significant healing journey. Between 2017 and 2020, I intensely experimented with these methods, some of which I continue to follow through 2024. While I found certain methods highly beneficial for alleviating my general heath, easing menstrual pain and improving hormonal health, I remain skeptical about the so-called 'energy healing' techniques.

As I reflect on this journey, I am reminded of Robert Murphy's memoir, *The Body Silent*. Murphy, an anthropology professor at Columbia University, chronicles his transformation from a healthy individual in 1972 to a quadriplegic by 1986 due to a spinal tumor. His book offers a detailed account of the tumor's progression, ultimately leading to full paralysis.

I find his work particularly resonant with my own experience, as he also undertook an anthropological field study of his illness. As I conclude this section, I draw inspiration from his narrative, particularly his reflections on the body and illness, which have influenced my understanding of my own research and healing process.

> This book was conceived in the realization that my long illness . . . has been a kind of extended anthropological field trip... It has been written with many purposes in mind, but the most important is to relate to the general public, and to disabled people everywhere, the social circumstances of the physically impaired and the meaning of this condition as an allegory of all life in society. (Murphy, 1987, p. ix)

In a similar way, I can say my thesis was conceived in the realization that my long illness has been a kind of extended anthropological field trip. Murphy's profound exploration of his physical transformation and its impact on societal perceptions offers invaluable insights into the lived experiences of those with significant health challenges.

Drawing on Murphy's work highlights the importance of understanding and documenting the subjective experiences of individuals in the context of health and illness. This approach aligns with the aim of my research, which seeks to analyze the personal narratives of women confronting reproductive health issues.

1.2. The Research Questions and Objectives

This dissertation explores why highly educated, professional, middle-class women with reproductive health issues use TCAM despite having convenient access[13] to modern biomedical treatments (*biomedicine*[14]). This section aims to present my research problem in a clearer and more concise manner, emphasizing the key points and rationale behind the study. From a sociological standpoint, I am interested in the factors driving women to seek alternative treatments for reproductive health issues and why this trend is not as evident in men's reproductive health. My initial questioning started at this point. The questions are: 1) Why were reproductive health issues so significant for women? 2) Why are women dissatisfied with biomedical approaches to treating these problems? Therefore, this thesis is founded on two primary premises: first, women's reproductive health is significant not only from a medical perspective but also from a sociological one. Second, the search for healing and treatment processes reveals both the strengths and limitations of biomedicine for women, warranting a feminist evaluation.

Research Questions: The central question of this study is: Why do highly-educated, professional, middle-class, urban women with reproductive health problems choose TCAM or Complementary and Alternative Medicine (CAM)[15] despite readily

13 We cannot ignore those who use alternative and traditional methods because they do not have access to institutional health services, but this issue is beyond the scope of this thesis.

14 For this thesis I use the concept biomedicine to refer to the Western scientific medical model. However, it is crucial to underline that biomedicine is a complex term which does not have a precise definition despite its widespread use in various contexts. Historically, biomedicine emerged in eighteenth-century Europe and gained prominence in the nineteenth century as a branch of biological sciences. It evolved into a dominant force in medical knowledge and practice, replacing older treatment methods with its emphasis on progress, empiricism, and rationalism (see Hardy 2001; Baranov 2008).

15 . For this thesis, for the porpose of in-text consistency, I choose to use TCAM throughout the text, unless authors use the term CAM. CAM includes a diverse array of therapies and practices that vary widely in scientific validation, safety, regulation, and underlying philosophy (Kelner & Wellman, 2000; Cohen, 2000). The classification of CAMs is inconsistent, leading to difficulties in understanding and application (Gollschewski, 2006). Chez and Jonas (1997) estimated over 300 therapies fall under CAM, characterized by a focus on wellness and the interaction between mind, body, and environment. CAMs are categorized into complementary therapies, used alongside conventional treatments, and alternative therapies, which replace conventional treatments (National Centre for Complementary and Alternative Medicine, 2002). While numerous definitions exist, a clear understanding of this group is not yet evident as construction of a single definition for CAMs is

available biomedical services? Additionally, the study explores: What are these women's subjective experiences with TCAM methods? How do they perceive their healing processes?

At this point, I would like to narrow my focus from broader research interests to specific research questions that can form the foundation of an operational research design. My project will consider the circumstances under which educated, professional, middle-class, urban women seek TCAM, as well as the health issues for which they pursue modern Western medicine. It examines how these women's experiences with TCAM might reflect on the current state of biomedical medicine and their personal health journeys. Additionally, I will inquire about the reproductive health problems they face, the reasons behind their choice of TCAM, whether they experience improvement in their health journey, their perceptions of the positive effects of these methods, their overall experiences, and whether they recommend these methods to other women with similar health concerns.

Research Objectives:

1 .To trace women's reasoning behind their preference for TCAM
2. To inquire through their experiences and perceptions of biomedical and biopsychosocial models of health and illness.
3. To explore how their preferences and perceptions influence their healthcare decisions and their views on their bodies and environments.

Scope and Rationale: This research focuses on highly-educated, professional, middle-class women who use TCAM for reproductive health issues. It aims to understand their decision-making processes and treatment experiences, and to analyze the conditions under which they choose TCAM over or in conjunction with biomedical methods.

In my research, I initially chose to examine women's reproductive health issues in a broad context rather than focusing on a specific condition because my main goal was

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complex and problematic (Kayne, 2002). Similarly, TCAM also includes a diverse array of therapies and a single definition is problematic

not to understand how a specific disease is cured.[16] Women's health has been fragmented and this fragmantation is problematic in itself (Nichols, 2000). These considerations led me to avoid limiting my research to a single disease classification.

Disease classification systems, like the WHO's ICD[17], inherently include some conditions while excluding others, impacting individuals' opportunities and life outcomes (Wadmann, 2023). While the ICD provides a global standard for categorizing health conditions, I chose not to focus on a specific predefined disease in my research. This approach allowed me to explore experiences that extend beyond these established definitions. This decision was guided by two main considerations. Firstly, from a theoretical standpoint, concentrating on a single disease[18] would have limited the scope of understanding the broader reasons why women seek TCAM. I believed that a broader scope would offer more comprehensive insights into the reasons behind women's choices of TCAM. Secondly, from a practical perspective, I initially lacked detailed knowledge about which specific reproductive health problems were most commonly addressed with TCAM, or the effectiveness and availability of these treatments. To address this gap, I began with a wider focus to collect preliminary data and gain a better understanding of the field before narrowing my study. Overall, by avoiding the fragmentation of women's health issues and starting with a general approach, I aimed to gain a richer understanding of the subject

[16] I initially considered narrowing my research to a specific reproductive health condition, such as menopause or uterine cancer, but found this approach methodologically limiting. Instead, I opted for a broader focus on female reproductive health issues. This decision allows me to explore a range of conditions and better understand why women seek TCAM.

[17] ICD (International Classification of Diseases) is a core function of the WHO, spelled out in its constitution and ratified by all 193 WHO member countries. The ICD has became WHO's responsibility when it was founded in 1948 as an agency of the UN. See for details: https://www.apa.org/monitor/2009/10/icd-dsm
An other disease classification system is The DSM (Diagnostic and Statistical Manual of Mental Disorders). The DSM and the ICD both use classification systems with diagnostic labels. However, the ICD is much older while the DSM has perceived more importance in mental health. See for similarity and differences of these systems: https://exploringyourmind.com/icd-and-dsm/

[18] My intention is never to cover up or trivialize the diseases that women specifically experience. On the contrary, I argue that conditions such as menstrual pain, endometriosis, polycystic ovary syndrome and irregular menstrual cycles, which are generally trivialized, are also of critical importance for one's general well-being. Trivializing, devaluing, and belittling some reproductive serious problems have been mentioned by my participants. For example, as revealed in my fieldwork, women suffering from endometriosis complain that this disease is ignored. Women who experience endometriosis complain that this disease is trivialized by society, and even by doctors (most of the participants from my fieldwork have indicated this issue in their interview).

and reflect the diverse experiences and challenges women face in their pursuit of reproductive health solutions.

1.3. Theoretical Background: The Intersection of Medicalization, Power and Women's Body

The relationship between medicine and the female body has long been a subject of critical analysis, particularly within the context of medicalization. The concept of medicalization, which refers to the process by which non-medical issues are framed as medical problems, provides a critical lens for understanding how women's bodies have been subjected to control and regulation through biomedical interventions. This section explores the evolution of this concept as a form of social control, especially concerning women's bodies and reproductive health, drawing on key theoretical perspectives.

Although declared to be a story of medical success, what lies behind modern medicine and the biomedical intervention to female body seem to be *medicalization*[19] and *pharmaceuticalization*[20] (Padamsee, 2011; see Conrad, 1992, 2007; Friedson, 1970a; Zola, 1972; Illich, 1976). At this point, it is essential to address how social science discussions have evolved regarding the relationship between medicine and the body. This will help contextualize the topic and provide a background for understanding the debates on women's bodies and reproduction within both medicine

19 The term medicalization is "the process by which non-medical issues come to be defined and treated as medical problems" (Vernon, 2015). In the following paragraphs, a more detailed discussion will be presented on medicalization.

20 In recent years, sociologists have examined the transformation of various human conditions into issues requiring pharmaceutical intervention. Pharmaceuticalization now encompasses conditions not traditionally viewed as medical concerns, as well as established medical conditions. This shift has prompted investigations into the reasons behind the growing reliance on pharmaceuticals for treatment and enhancement. Some of these studies specifically focus on women's reproductive health, mainly contraception and infertility treatment pills. In Padamsee (2011)'s words, "First, it offered a compelling picture of the 'good work' obstetricians and gynecologists do, which involves enabling women of reproductive age to control their fertility through contraception and infertility treatment and providing symptom relief and preventive benefits to older women by increasing compliance with hormone therapy regimes. Second, it included pharmaceutical technology in every aspect of the doctor's work, portraying pharmaceutical corporations as the physician's 'natural partner', and women patients as passive, disempowered objects of medical practice" (p.1342). See Padamsee, T. J. (2011). The Pharmaceutical Corporation and the 'Good Work' of managing women's bodies. Social Science; Medicine, 72(8), 1342–1350.

and the social sciences. A comparative perspective that considers gender and power relations is crucial. To grasp the dynamics underlying women's reproductive health, I believe a two-dimensional approach is necessary: one that integrates theories on the relationship between medicine, knowledge, and power, alongside feminist theoretical perspectives.

Foucault, in *The Birth of the Clinic: An Archaeology of Medical Perception* (1973), examines the emergence of the medical profession, particularly the clinic, in 18th century France. He problematizes the shift from viewing individuals as sick to seeing them as 'patients,' and the invention of 'diseases' as products of changing medical perspectives and power structures. This transformation not only altered medical discourse but also redefined the relationships between patient, disease, and doctor. The drive to homogenize, classify, and centralize medical knowledge led to the establishment of health centers like hospitals and dispensaries.

In the 1970s, critiques of the concept of *medicalization* became more critical. Scholars like Zola (1972) and Illich (1976) argued that medicalization serves as a form of social control that undermines freedom. Zola critiqued the political economy of medicine, asserting that it had become a dominant institution for social regulation, surpassing religion and law as sources of 'truth' and control. He argued that medical knowledge was monopolized by authorities to maintain their autonomy, shifting the focus of medicine from promoting health to exerting social control.[21] Illich (1976) argues that modern medicine is harmful both physically and socially due to the dominance of medical professionals, which fosters an overreliance on medication as a singular solution. This dependence obscures the political factors contributing to poor health and strips individuals of their ability to manage their own well-being.[22] According to Illich, modern medicine convinces people that they are sick and

[21] This 'medicalized sociality' was seen as a result of increased medicalization of daily life. "Medicalized sociality" is founded on an implied social agreement among patients, healthcare providers, and the medical industrial complex, as identified by Stanley Wohl (Burfoot & Güngör, 2022, p.28).

[22] Illich's argument provides an understanding for the contemporary situation of women's reproductive health since an increasing number of women are relying on medical interventions, including assisted reproductive technologies, in order to conceive or facilitate childbirth.

powerless, requiring technological interventions, thus undermining their autonomy in healthcare decisions.

During the same period, thinkers like Szasz ([1961] 1974), Laing (1967), Goffman ([1961] 1968), and Foucault[23] ([1963] 1973) examined the relationship between medicine and social control, arguing that definitions of normality and pathology are socially constructed through medical expertise and discourse (Nye, 2003, p.116). They contended that medicine increasingly took on roles in regulating society traditionally held by law and religion (Szasz, 1974; Foucault, [1965] 2006). Kennedy and Kennedy (2010) later expanded on this, suggesting that medicalization is a social construct, rooted in Parsons' concept of the 'Sick Role,'[24] where illness is institutionalized beyond just a physical condition (Parsons, [1951] 1978, p. 81).

Kennedy and Kennedy (2010) explain that to assume the 'Sick Role,' individuals must take on the role of 'patient,' which legitimizes their temporary withdrawal from normal responsibilities while requiring them to follow medical advice for recovery. Parsons argued that medicalization and the boundaries between medical and non-medical realms arise from the functional relationship between medical practice and the sick role, which sanctions deviations from social norms ([1951] 1978, pp. 2-3). They view medicalization as a social construction where "facts merge into values" (Kennedy & Kennedy, 2010, p. 4). Berger and Luckmann ([1967] 1991) describe the social construction of reality as the process through which people create and share contested meanings that become institutionalized as 'objective truths.' Social constructionists challenge the notion of objective truths in medical science, arguing that such claims are socially constructed rather than absolute (Kennedy & Kennedy,

[23] Foucault played a significant role in shaping the evolution of the concept of medicalization into its current interpretations. Apart from his notable work on punishment, Foucault authored multiple essays in the mid-1970s focusing on medicalization. In his 1974 lecture titled "The Birth of Social Medicine," he discussed the concept of "medical intervention" within "bio history," highlighting its emergence in the 18th century (Nye, 2003, p.117).

[24] Parsons' work on the sick role has been criticized by Burnham (2012; 2014) for overlooking or inadequately accounting for several important dimensions of the illness experience. These include the dynamics of the physician-patient relationship and inherent power imbalances, the challenges patients face in navigating medical authority and asserting their own agency, the role of caregivers in the illness experience, and the influences of gender, socioeconomic status, and race on illness experiences and outcomes (Kokanović & Flore, 2017).

2010, p. 4). This perspective highlights that medicalization, both within medicine and medical sociology, is a social construct challenged by the argument that medical science does not possess objective truths about the body and illness.

In the 2000s, Peter Conrad, a student of Zola, expanded on the concept of medicalization, emphasizing the growing trend of nonmedical issues being redefined as medical problems (Collyer et al., 2015). Conrad (2007) argued that medicalization occurs when issues are framed in medical terms, understood within a medical framework, and addressed through medical interventions. In essence, 'to medicalize' means to essentially render it as a medical concern.[25] He also noted that phenomena can be both medicalized and de-medicalized[26] over time (Conrad, 2013). He (2005) identified three major changes in medicine over the past two decades that have shifted the drivers of this phenomenon: 1) advancements in biotechnology, particularly in the pharmaceutical and genetic fields, 2) the influence of consumer behavior, and 3) the rise of managed care systems. While physicians still act as gatekeepers, their role in expanding medicalization has diminished, with commercial and market interests now playing a more significant role.[27] The core definition of

[25] Non-medical issues, such as pregnancy and birth, were redefined and treated as medical concerns, which was a key focus of critical feminist medicalization theories. Many instances of medicalization have been thoroughly recorded and described, spanning a wide range of areas such as childbirth, obesity, alcoholism, anorexia, baldness, erectile dysfunction, female sexual dysfunction, menopause, sleep issues, and death. Conrad's arguments delve into the broader concept of medicalization and its evolving facets within the realm of healthcare. While women's reproductive health was not the primary emphasis of his article, it contributes to the overall understanding of how medicalization operates in various spheres, including reproductive health. He explores how medicalization, as a process, has undergone changes, shifting from being primarily influenced by healthcare professionals and institutions to increasingly being driven by commercial and profit-oriented entities, such as pharmaceutical industries. This shift in influence affects how health issues, including those related to women's reproductive health, are framed, treated, and perceived within the medical landscape.

[26] For example, the concepts of homosexuality and masturbation can be counted as the de-medicalization (Collyer et al., 2015). Moreover, re-medicalization is still a possibility after such processes. Similarly, Halfmann (2011) argues that medicalization and de-medicalization can happen concurrently, and even when one seems to prevail, it is often an incomplete transformation.

[27] Pharmaceutical companies are now central to modern medicine, influencing a wide range of areas. They help define diseases, fund clinical research, educate physicians, and influence prescribing behaviors (Nguyen, 2021). As Conrad (2005) observed, medicine today is increasingly shaped by profit-driven corporations seeking to dominate markets with their medical products. The increasing pharmaceuticalization of society have been well-documented, highlighting the transformation of human conditions into treatable disorders and the significant influence of the pharmaceutical industry on medical practice and research outcomes (Moynihan & Cassels, 2005; Conrad, 2007; Lexchin et al., 2003; Wazana, 2000).

medicalization remains consistent, but new pharmaceutical and genetic therapies are increasingly driving the creation of new medical categories.

Building on the broader discussions of medicalization, it is crucial to examine how this phenomenon intersects with gender, particularly concerning women's bodies and reproductive health. The relationship between women, health[28], and medicine has always been complex and paradoxical. Feminist scholars critically engage with the highly gendered nature of modern medicine, utilizing the concept to highlight the adverse effects of institutionalized medicine on women.[29] Throughout a woman's life, natural transitions such as childbirth and menopause continue to be treated as medical conditions (Taylor & Woods, 1996). Feminist critiques argue that the medical field is fundamentally patriarchal, reinforcing gender disparities by using medical concepts to govern and control women's bodies, particularly in areas such as pregnancy, reproductive and sexual health ((Ehrenreich & Ehrenreich, 1978; Ehrenreich & English, 1973; Du Rose, 2015).

Through the processes of medicalization of the female body, feminist scholars argue that women have been increasingly alienated from their own natural cycles. Today, childbirth is often perceived as a medical procedure, with rising rates of cesarean births. Birth control pills are prescribed to girls as young as 15, many women suffer

[28] Health and illness cannot be taken only as a medical phenomenon. Rather, it is "a sociologically conceptual and institutional phenomenon, which holds the determining value of a wide range of aspects from the quality of the physical environment" (Cengiz, 2018, p. 134; Sever, 2015). There should be a close relation between how people give meaning to the concepts of disease and the treatment preferences of a society. Ivan Illich (1976) in his groundbreaking book, Medical Nemesis, writes "Each civilization defines its own diseases. What is sickness in one might be chromosomal abnormality, crime, holiness, or sin in another".

[29] During the second wave of the women's movement, feminists endeavored to highlight women's health concerns. Presently, their achievements are evident through increased female representation in medicine and amplified focus and resources dedicated to women's health. However, feminists maintain a critical stance toward the heavily gendered nature of medicine, pinpointing its role in perpetuating social disparities (Plechner, 2000). Moreover, Voices of the Women's Health Movement is a compilation of two volumes edited by Barbara Seaman and Laura Eldridge. The book delves into the diverse perspectives and experiences within the women's health movement. It gathers writings, essays, and narratives from various women, activists, and professionals involved in advocating for women's health rights. The content covers a wide array of topics, including reproductive rights, healthcare access, feminist perspectives on medical practices, and the challenges faced by women in navigating the healthcare system. Overall, the book serves as a comprehensive anthology capturing the voices and struggles within the women's health movement across different periods and issues. For details, See Seaman, B., & Eldridge, L. (Eds.). (2012). Voices of the Women's Health Movement (Vol. 1). Seven Stories Press.

from hormonal disorders, and menopause is medicalized with the routine prescription of artificial hormones. Medicalization has transformed childbirth into a professionalized event, stripping it of its cultural significance and reframing it within a medical context (Prosen & Krajnc, 2019). Additionally, medical technology has predominantly focused on symptom relief for chronic and severe conditions like PCOS, Premenstrual Syndrome (PMS)[30] (Freeman et al., 1995; Richardson, 1995; Lorber & Moore, 2002b), Premenstrual Dysphoric Disorder (PMDD) (Nworie, 2018), and endometriosis[31] (Wang et al., 2021). This thesis acknowledges that within the context of women's reproductive health, the phenomena of medicalization and pharmaceuticalization significantly impact female health.

The continuing medicalization of women's lives is intertwined with prevailing ideologies about the body[32] and significant shifts in healthcare structures, particularly the increasing importance and complexity of technological advancements (Plechner, 2000). Feminist scholars like Harding (1997) and Bartky (2003) have expanded upon

[30] The evolution and emergence of the contemporary understanding of PMS has been explained through medical acknowledgment and cultural awareness of symptoms related to the premenstrual phase. According to Richardson (1995) the conceptualization of these symptoms as constituting a clinical syndrome is a more recent development, dating back only 40 years. These symptoms, predominantly psychological in nature with emotional, somatic, and behavioral components, lack a clearly established cause, exhibit varying prevalence across different cultural contexts. However, the empirical foundation supporting the existence of PMS remains ambiguous, and the term "syndrome" in this context carries multiple implications, prompting skepticism among some researchers. For a detailed discussion See Richardson J. T. (1995). The premenstrual syndrome: a brief history. Social science & medicine (1982), 41(6), 761–767. https://doi.org/10.1016/0277-9536(95)00042-6.

[31] Endometriosis, a chronic condition reliant on estrogen, impacts women in their reproductive years. According to the European Society of Human Reproduction and Embryology (ESHRE), it affects over 6-10% of women aged 25-30 (Bodean et al., 2018). The recent study of Wang et al. (2021, p. 2404) provides a different view for treating EMs with GFPs alone or in combination with western medicine, by arguing that it had achieved satisfactory solutions and was considered as an alternative drug for treating EMs.

[32] To understand the connection between the developments in 18th century France as Foucault explained in his work The Birth of the Clinic, the context of knowledge-power relations and modern biomedical discourses, and their relation with women's bodies, it is necessary to turn to feminist theories. Jordanova's historical analysis of gendered distinctions in 18th and 19th-century France and Britain, examining the cultural and natural divide, can provide valuable insights. One of the most entrenched dualisms in modern times is the association of women with nature and men with culture, a notion as old as the development of culture by humanity itself. This distinction places culture as not only different from but also superior to nature, relying on culture's power to transform nature through the means of socialization and acculturation (Jordanova, 1983). In her article, Jordanova discusses related dichotomies such as body/mind and emotion/reason, and contrasts superstition and tradition with enlightenment and progress. This contrast legitimized 'enlightened' Western male doctors to govern women in matters of childbirth and childcare.

the concept as it applies to women's bodies. They argue that labeling natural processes such as menstruation, childbirth, and menopause as medical issues requiring treatment contributes to the subordination of women. The historically male-dominated medical profession exerts control over women's bodies, reinforcing patriarchal power dynamics. A recent Turkish study by Cindoğlu and Sayan-Cengiz (2010) draws a parallel, arguing that the medicalization of women's reproductive processes diminishes women's autonomy and control over their own bodies, particularly during pregnancy and childbirth. However, more recent feminist scholarship has shifted focus from the social control mechanisms discourse to exploring the relationship between the body and its social interactions. Feminist scholars now attempt to unravel the social and cultural dimensions of the body, emphasizing *embodiment*[33], identity, and the interplay between biology and culture in shaping bodily experiences.

Chrisler (2004) captures this shift in perspective, advocating for a more nuanced understanding of the female body and the ways in which it affects women's experiences. She discusses the varied and complex nature of reproductive processes, noting that these experiences can significantly impact women's physical and emotional well-being. To elaborate on this, Chrisler's indicates:

> It is time for a more sophisticated perspective on the female body and the ways that living in one affects women's experiences. Women do bleed, birth, and flash. Some get pregnant when they don't want to, and others don't get pregnant when they do want to. Some pregnancies result in joy; others result in sorrow. Some births are exciting and empowering; others are disappointing and disempowering. Some women have mild menstrual and menopausal symptoms; others have moderate or severe symptoms that interfere with their social and professional lives. Many women have been harmed by the silence and stigma that surrounds infertility, menarche, miscarriage, and menopause. Body image, gender identity, and self-acceptance are a few of the many factors that can be affected by the reproductive processes of the female body. If these factors can be discussed in feminist therapy, why not also discuss the physiological processes that provide part of the context of the experience? (Chrisler, 2004, p.1)

[33] Embodiment is a concept which refers to the lived experience of biological processes, such as reproduction and childbirth, which are mediated by cultural understandings and practices (Martin, 2003 [1987]).

Different feminist viewpoints—including liberal, radical, Marxist, and socialist feminism essentialist/cultural, African American, existential, cyborg feminism, and ecofeminism —concur that patriarchy functions as a system of power rooted in male supremacy. While they may differ in their explanations of women's subordination, they share a common goal of examining the underlying reasons for this subordination. Radical feminism, in particular, raises critical points about the medicalization of menstruation, highlighting issues such as the control over women's bodies, the pathologization of natural processes, the reinforcement of institutional power and patriarchy, and the commodification of menstruation through the commercialization of menstrual products and fertility treatments (Aengst & Layne, 2013; Delaney et al., 1977; Martin, 1987). The medicalization of reproduction often serves to reinforce patriarchal norms, with healthcare systems and medical professionals exerting authority over women's reproductive decisions, sometimes at the expense of women's autonomy.

1.4. A Transition in Thought: The Growing Integration of TCAM Practices in Medicine

> I have both General Health Insurance (GSS)[34], and private health insurance. But I don't use it much. But of course, depending on the situation, if I go to a private hospital, I use health insurance to some extent. I use health insurance without drug coverage. Because I don't use medicine much. I mean, normal hospital doctor medications... I had to take the things prescribed, yes, when I had Covid this year. But as I said, since I do not use medication for anything normal, I have insurance that does not cover medication.[35] Pakize

This excerpt is from one of the respondents from my fieldwork, Pakize, 42 years old, who mentions that although she has both *General Health Insurance* (GSS)[36] and

[34] She refers to Genel Sağlık Sigortası (GSS).

[35] Hem genel sağlık hem özel sağlık sigortam var ama pek kullanmıyorum. Ama hani tabi duruma göre, yani özel hastaneye gidersem biraz sağlık sigortasını kullanıyorum. İlaç kapsamsız bir sağlık sigortası kullanıyorum. Çünkü ilaç pek kullanmıyorum. yani normal hastane doktoru ilaçlarını… Mecburen hani yazılan şeyler olduğunda evet aldığım oldu bu yıl kovid geçirdiğimde. Fakat dediğim gibi normal şeye ilaç kullanmadığım için ilaç kapsamsız bir sigortam var. Pakize

[36] The health insurance provided by the state in Türkiye is called General Health Insurance (GSS). This insurance is administered by the Social Security Institution (SGK) of the Republic and provides access to health services to all citizens and foreign nationals living in the country. For details See

private health insurance, she does not use them much. She primarily turns to her insurance for private hospital visits and does not use drug coverage, as she infrequently needs medication. An exception was during her COVID-19 illness when she used prescribed medications. Pakize's minimal reliance on health insurance reflects her low overall need for medical treatment, but it also indicates a shift in her views and access to healthcare. Pakize's statements reflect not only an individual inclination but also align with broader trends indicated by WHO reports.

According to the WHO report from March 31, 2003, there has been increased global interest in traditional medicine over the past decade.[37] The use of TCAM has grown, with WHO's 10-year plan (Adams et.al, 2009). The WHO Global Atlas reports that over three-quarters of the global population uses TCAM, with women being significant users (Ong et al., 2005; Bowe et al., 2015; Eardley et al., 2012; Hall et al., 2011). The 2018 Declaration of Astana by WHO and UNICEF highlights the integration of traditional medicine into primary health care, building on the 1978 Alma-Ata Declaration's focus on Universal Health Coverage. This shift reflects a broader trend in global health policies and attitudes towards traditional medicine (Yoshino et al., 2023).

From the 1990s to 2020s, the use of TCAM has significantly increased (Nahin et al., 2024).[38] According to the research of Misawa et al. (2019), in which they studied 32 countries using data from the International Social Survey Programme and the World Bank (WB), the prevalence of TCAM usage among the 32 target countries showed great variations. Table 1. shows the social survey summary. Similar patterns of TCAM use have been observed in Türkiye (Tan et al., 2004).

Kutluk, M. T., Aydın, S., Uçar, E., Kirazlı, M., Ahmed, F., Şengelen, M., ... & Coutts, A. P. (2022). The political economy of the health in Turkey.

[37] Traditional Medicine Report by the Secretariat (Rep. No. Fifty-Sixth World Health Assembly A56/18). (2003). WHO.

[38] Early research by Eisenberg et al. (1993) revealed that an estimated 61 million Americans utilized at least one form of alternative therapy, with 22 million seeking care from alternative healthcare providers, and the number of visits to these providers surpassing those to primary healthcare physicians. Subsequent studies reinforced these trends, such as the report by Barnes et al. (2008), which found that approximately 38% of American adults and 12% of children used some form of CAM, including therapies like natural products, deep breathing exercises, and chiropractic manipulation.

Table 1. Social Survey Summary. Taken from Misawa et al.'s research, The impact of uncertainty in society on the use of traditional, complementary and alternative medicine, 2019

Country	Date of Collecton	Gross Sample Size	Stample Size	Response Rate	Min Age	Max Age	Mean Age	Analyzed Samples
Turkey	Npv 2011 – Jan 2012	3150	1559	49,5	17	92	42,1	1398

Frass et al. (2012) reviewed the growing acceptance among both the general public and healthcare professionals. Clarke et al. (2015) highlighted the increasing trend of over the past decade, noting various demographic factors contributing to this rise. The National Center for Complementary and Integrative Health (NCCIH)[39] has consistently reported a steady increase in the adoption of various complementary health approaches. Aligning with trends first identified by Eisenberg et al. (1993), TCAM use has significantly risen from the 1990s to 2024.[40]

Public interest has surged globally and the global market for TCAM is experiencing rapid growth.[41] Figure 1. Graph titled *Use of Complementary Health Approaches: 20-Year Trends in US*, presents that there has been an increase in acupuncture, chiropractic, guided imagery, progressive muscle relaxation, massage therapy, meditation, naturopathy, and yoga (Nahin et al., 2024).

[39] The NCCIH is the leading federal agency for scientific research on complementary and integrative health practices. It is one of the 27 Institutes, Centers, and Offices that form the National Institutes of Health (NIH), which operates under the U.S. Department of Health and Human Services.

[40] Recent NCCIH data indicates that the percentage of U.S. adults utilizing various complementary health approaches has more than doubled in some categories. According to NCCIH (2024), the increase in CAM usage can be partially attributed to the higher quality research supporting its efficacy, inclusion in clinical practice guidelines, and expanded insurance coverage for approaches such as acupuncture. For more details, you can visit https://www.nccih.nih.gov/about

[41] Recent data indicates that the global CAM market, valued at approximately USD 108.32 billion in 2022, is projected to grow significantly, reaching an estimated USD 913.82 billion by 2032. This growth represents a compound annual growth rate (CAGR) of 23.77% from 2023 to 2032. The rising demand for CAM therapies can be attributed to increased healthcare expenditure, increasing shift in the understanding in the approach to health and illness and the growing preference for holistic and preventive healthcare practices (Fjær et al., 2020; The Brainy Insights, 2023).

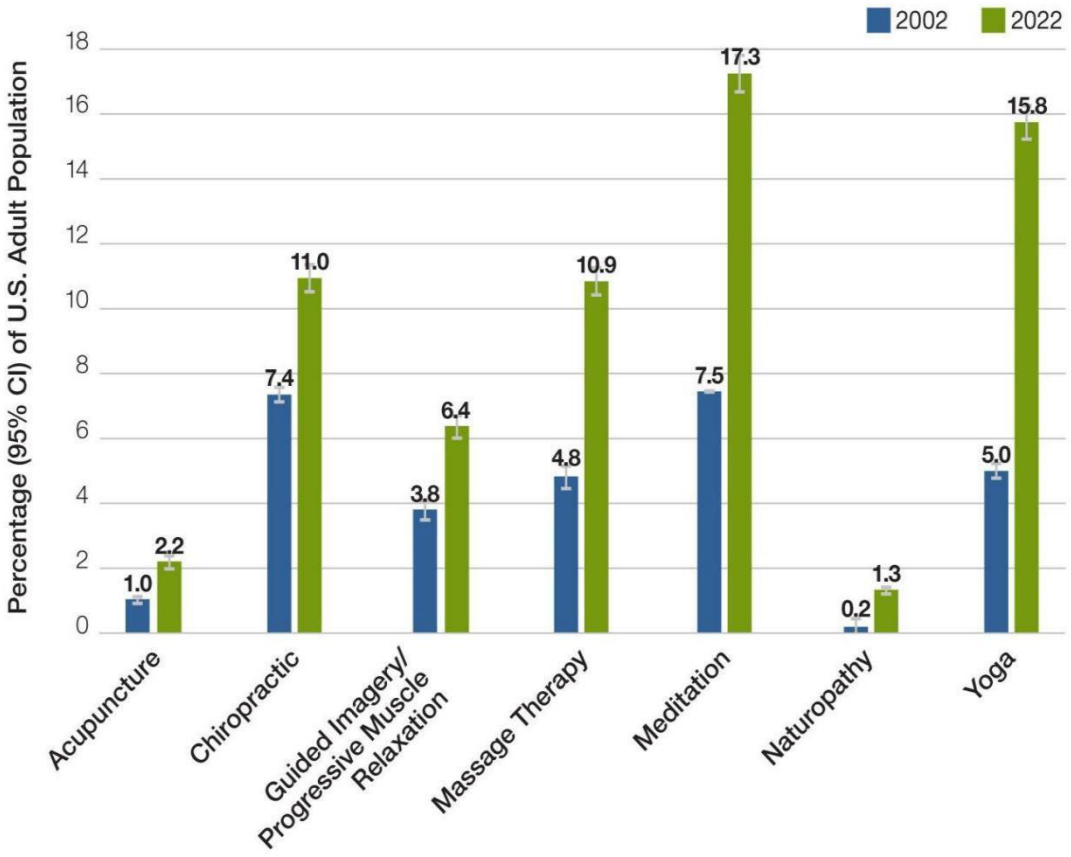

Figure 1. Graph Titled Use of Complementary Health Approaches: 20-Year Trends. Source: Nahin et al., (2024).

1.4.1. The Rise of TCAM and Holistic Practices Among Women

Similar to the global trend of increasing TCAM usage, this section will introduce the literature on the rise of TCAM and holistic practices among women. This literature reveals that women use these practices more frequently than men, with a predominant focus on reproductive health. This trend not only highlights the gender disparity in use but also provides a framework for understanding why reproductive health is a predominant area of concern. This background supports the exploration of one of the central questions of this study.

Numerous studies indicate that women constitute a significant majority of TCAM users (Tangkiatkumjai et al., 2020; Misawa et al., 2019; Mollaoğlu et al., 2013; Eardley et al., 2012; Hall et al., 2011; Rayner et al., 2011; Cardini et al., 2010; Bishop et al., 2007; Adams et al., 2005; Tindle et al., 2005; Upchurch & Chyu, 2005;

Verhoef et al., 2005; McFarland et al., 2002; Ernst & White, 2000; Sharma, 1995; Bael, 1998). Research by Eardley et al. (2012) and Rayner et al. (2011) highlights high engagement among women in fertility enhancement.

Tindle et al. (2005) and Verhoef et al. (2005) document greater prevalence of CAM use among women compared to men. Ernst and White (2000) and Sharma (1995) also note this gender disparity. Bishop et al. (2007) emphasize that women's holistic health beliefs drive their use. Adams et al. (2005) observe that middle-aged Australian women with cancer often seek naturopathy and herbalism. Upchurch and Chyu (2005) and McFarland et al. (2002) confirm high usage among American and Canadian women. Hall et al. (2011) show significant use among pregnant women, while Rayner et al. (2011) specifically address its role in fertility enhancement. Figure 2. illustrates the significant increase in TCAM use among women across different regions, age groups, and education levels. The percentages for each category are clearly labeled to provide a visual representation of the data.[42]

Most studies indicate that the use of TCAM is influenced by factors such as age, gender, ethnicity, financial status, spiritual beliefs, and healthy lifestyle habits (Arı & Yılmaz, 2016; Hirai et al., 2008; Sirois & Gick, 2002; Ellison, 2012). Bael (1998) examines the use of these therapies among women in the U.S., focusing on reproductive health. This includes herbal medicine, homeopathy, acupuncture, and acupressure for conditions like menstrual disorders, infertility, menopause, and pregnancy issues (James et al., 2019). Many women use TCAM to maintain maternal health and well-being (Shewamene et al., 2020), with increased use reported during perimenopause (MacLennan et al., 1996) and menopause (Eisenberg et al., 1998; MacLennan et al., 2002).

[42] At the social level, the prevalence of TCAM usage regarding visits to practitioners among the 32 target countries showed great variations (Eardley et al., 2012). Regional variations were significant, with 85% of women in Asia utilizing TCAM practices (Rayner et al., 2011) compared to 55% in Europe (Rayner et al., 2011). Age and education also played a role, with 70% of women aged 45-54 (Hall et al., 2011) and 80% of women with a university education (Hall et al., 2011) engaging in TCAM practices. Health conditions influenced TCAM usage as well, with 80% of women with arthritis (Bishop et al., 2007) and 75% of women with musculoskeletal disorders (Bishop et al., 2007) seeking TCAM treatments.

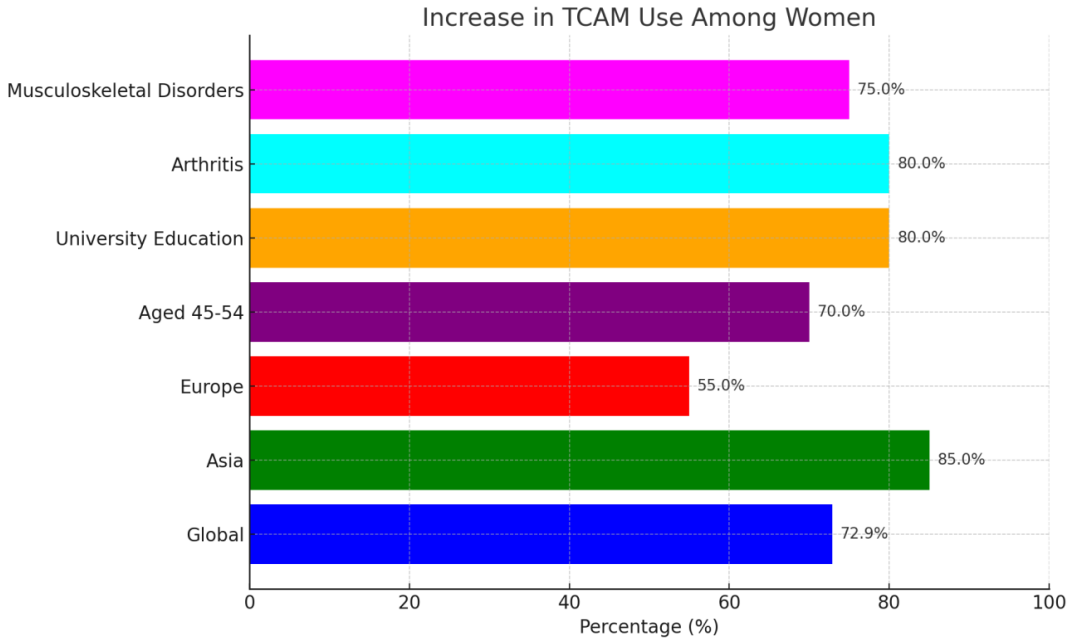

Figure 2. The Significant Increase in TCAM Use Among Women. I prepared the graph using information from various sources, including Eardley et al. (2012), Rayner et al. (2011), Hall et al. (2011), and Bishop et al. (2007).

Women were more likely than men to consult naturopaths, iridologists, and reflexologists (MacLennan et al., 1996). Among Australian women, 3.7% had endometriosis, with premenstrual syndrome (41.2%) being the most common symptom, followed by irregular bleeding (22.2%), heavy periods (29.8%), and severe period pain (24.1%) (Fisher et al., 2016). Those with endometriosis were more likely to seek massage therapy, acupuncture, and use vitamins/minerals, yoga/meditation,[43] or Chinese medicine. Women with PMS preferred osteopaths, massage therapists, and naturopaths/herbalists. Severe menstrual pain sufferers[44] were more likely to use aromatherapy, herbal medicines, Chinese medicine, and other therapies compared to non-sufferers (Fisher et al., 2016).

For the Turkish case, TCAM methods are frequently used for infertility (Balkan et al., 2022; Ataman et al., 2019; Özkan et al., 2018). Balkan et al. (2022) found that 60.4% of women with infertility diagnoses used CAM, with popular methods

[43] For example, the use of yoga increased from 5% in 2002 to 15.8% in 2022, and the use of meditation rose from 7.5% to 17.3% over the same period (Nahin et al., 2024).

[44] No significant differences were noted in CAM use for irregular bleeding or heavy periods, except for reduced visits to massage therapists or use of yoga/meditation.

including nutritional supplements like the 'onion cure' (30.2%), honey application into the vagina (46.4%), spa visits (50.0%), and prayer (74.7%).[45] Common traditional practices involve consuming onions (65.1%), figs (45.2%), inserting sheep tail fat into the vagina (42.9%), and using amulets[46] (34.1%) (Özkan et al., 2018). Additionally, Kaygusuz (2020) and Yildirim (2006) reported that pregnant, nursing women, and those with gynecological cancer used to boost milk production, treat infections, and enhance immunity. Akpunar (2015) noted use among gynecologic cancer patients for immune support, reducing treatment side effects, and relaxation. Nazik et al. (2012) found that herbal therapy was the most common TCAM method (90.2%) among gynecological cancer patients. These studies indicate that TCAM is widely used by women for various reproductive health issues, often focusing on fertility, pregnancy, and birth.

In the context of addressing the methods which are outside of biomedicine, it is important to consider Holistic Movement Practices (HMPs) such as yoga, Tai Chi, and Qi Gong. These practices are also grouped under the heading of alternative therapies. Just like TCAM methods, there is an increase in the use of HMPs in the Western countries (Cagas et al., 2022, Ren et al., 2017) as well as in Turkey (Cengiz et al., 2021). Vergeer et al. (2018) indicates that, the users of yoga studios are significantly more likely to be women[47]. After this short introductory section about the increase in both TCAM methods and HMPs and the fact that these two practices are used mostly by women, we will continue with the significance of studying women's reproductive related health in the next section.

[45] The researchers used a Questionnaire on CAM Methods and Complementary, Alternative and Conventional Medicine Attitude Scale (CACMAS) as data collection tools.

[46] An amulet, commonly written on paper, leather, cloth, or metal plates, contains prayers, verses, or symbols. These symbols are particularly significant in religions such as Islam, Christianity, and Judaism. The creation of an amulet involves specific rituals and prayers. The content and purposes of amulets vary. Some amulets are solely for protection, while others are used to seek help in matters such as health, prosperity, or success

[47] This study also shows that the women users mostly have higher levels of education and socio-economic background (Vergeer et al., 2018, p. 5). To gain insight which parameters are effective in doing yoga and to examine the gender differences of the users' participation motivations, you can check Cgas et al. (2022). See Cagas, J. Y., Biddle, S. J., & Vergeer, I. (2022). For exercise, relaxation, or spirituality: Exploring participation motives and conformity to masculine norms among male and female yoga participants. International Journal of Environmental Research and Public Health, 19(2), 770. https://doi.org/10.3390/ijerph19020770

1.5. Significance of The Study: Rethinking Population Control in Women's Reproductive Health

The significance of this thesis study lies in its critical examination of the historical and contemporary frameworks surrounding women's reproductive health, particularly focusing on the tension between population control and reproductive rights. While past approaches have often reduced women's reproductive health to a tool for controlling population growth, especially in developing countries, this thesis seeks to challenge and rethink this narrative.

The issue of women's reproductive health has been included in research as a population control tool for many years (Morison, 2021; Hartmann, 2016; Wang & Pillai, 2001; Pollack Petchesky, 1995). Since the 1960s, international family planning programs have often been characterized by the concept of 'population control'. This term has typically been associated with a singular focus on limiting fertility percentages, with an aim of slowing down the high population rates especially in the developing countries (Hartmann, 2016; Wang & Pillai, 2001). The origins of population control as a development strategy can be traced back to the intellectual movements that ultimately spurred organized birth control initiatives in Europe and the USA. These movements aimed to manage population growth through various methods and ideologies (Hartmann, 2016). This focus on controlling women's reproduction and bodies through population control has faced significant criticism from feminist scholars (Ross, 2017; Ross et al., 2017; Mollen, 2014; DeLucca and Lobel, 2014; Doyal, 1995; Lane, 1994). In response to the deeply problematic ideals of population control as a development strategy, women's rights activists have strongly criticized the family planning approach for its narrow focus on targeting women and its reductionist view of reproduction as merely a biological process, overlooking its cultural and socio-political dimensions (Morison, 2021; Morison & Macleod, 2015).

The feminist movement catalyzed a significant shift in the approach to women's reproductive health. This transformation was notably marked by the 1994 International Conference on Population and Development (ICPD) in Cairo, where

international stakeholders increasingly recognized women's reproductive health as an autonomous and essential concern (Wang & Pillai, 2001). The Cairo Program of Action, established by the United Nations during this conference, underscored reproductive rights as fundamental human rights (Wang & Pillai, 2001, p. 233). The Cairo Declaration advocated for an approach that situates family planning within the broader framework of reproductive health care (United Nations Population Fund, 1994). This marked a departure from the earlier paradigm that prioritized population control over women's health, positioning reproductive health as important in its own right. As Morison notes, 'reproductive health' is a relatively recent concept (Morison, 2021, p. 172).

This new framework can be seen as an incorporation of feminist perspectives, emphasizing reproductive rights and gender equality. However, Pollack Petchesky (1995) argues that despite this shift, the ICPD Program of Action remains grounded in conventional development models that may impede the full realization of feminist ideals. While the program embraces feminist principles, it operates within a framework that may not entirely support their attainment (Pollack Petchesky, 1995, p. 152). Pollack Petchesky highlights the ongoing challenge of bridging the gap between body politics, sexuality, reproduction, and global economic transformation—a challenge that continues to confront women's movements in the 21st century.

Chrisler (2014) distinguishes between 'reproductive rights' and 'reproductive justice,' with the latter being a multifaceted concept rooted in social justice and positive rights[48]. Goldberg (2009) further explains that reproductive justice encompasses a broad spectrum of issues, including the right to make decisions about one's own body, access comprehensive reproductive healthcare, and ensure equality for women in both physical and mental health. Morison (2021) argues that while the recognition of reproductive rights on a global scale marked significant progress, the radical potential of this discourse has been limited by Western liberal individualism,

[48] For a detailed discussion on "reproductive justice" Chrisler's article proceeds to explore how the articles by Mollen (2014) and DeLucca and Lobel (2014) contribute to the understanding of reproductive justice.

which emphasizes personal freedom and choice. This focus often neglects the broader social and political contexts in which reproductive decisions are made, reducing reproductive health to a matter of individual choice (Rebouché, 2017).

In summary, women's reproductive health has historically been intertwined with population control efforts, particularly aimed at reducing fertility rates in developing countries. Although the 1994 ICPD in Cairo marked a shift toward recognizing women's reproductive health as a fundamental human right, the development framework of the ICPD still falls short of fully supporting feminist goals. The debate on women's reproduction reveals two distinct perspectives: one that emphasizes population control within developmental frameworks, and another that prioritizes personal freedom and choice, often overlooking the broader social and political context. By employing a critical lens, this thesis aims to bridge the gap between the narrow focus on population control and the broader feminist perspective that emphasizes the autonomy of women. It seeks to contribute to the ongoing debate by challenging both the traditional population control approach and the individualistic, choice-centric model, advocating instead for a more nuanced understanding that incorporates the socio-political contexts. This makes the thesis significant in advancing a more comprehensive and just approach to women's reproductive health.

The details of the research methodology and the method of the study are presented in Chapter 2. Following that chapter, the conceptual framework on the different models to medicine as biomedicine and biopsychosocial medicine are discussed in Chapter 3. After this background and conceptual frameworks, the findings of the study are presented in Chapter 4 and 5 under the headings of Finally, an overall summary is presented in the Conclusion chapter.

CHAPTER 2

RESEARCH METHODOLOGY

In this research I followed feminist methodology in order to understand and analyze the experiences of the highly educated, professional, middle-class women with reproductive health issues. In this chapter, firstly I will give an overview of the approaches to qualitative research and why qualitative methods are more needed in women's health research from a feminist perspective. Then, I will continue with presenting my fieldwork, my feminist methodological approach, and my stance in building rapport and data analysis.

There are a variety of theoretical perspectives within qualitative research, which are identified as three main approaches: empiricist, contextualist, and constructivist (Henwood and Pidgeon, 1994). Firstly, the empiricist approach attempts to work with the values of the natural scientific approach for the analysis of social sciences and gives priority to describing people's belief systems as much as possible. The validity and reliability of the findings are at the core with the object of generalizing.[49] This approach is descriptive rather than analytic (Murray and Chamberlain, 2000). The second one is the contextualist approach which is more concerned with the social, historical, and cultural context. A concern with the production of inter-subjective meaning and the development of theory, this approach integrates the complexity of participant's contexts.[50] The third main approach to qualitative studies is the constructivist perspective[51] which attempts to analyze language and its role in

[49] Among this approach, the content analysis method is one of the most used methods.

[50] A popular method within this approach is grounded theory which was constructed by Glaser and Strauss (1968), which tries to identify the underlying structure in what people have to say (Murray and Chamberlain, 2000, p.41).

[51] Constructivist perspective draws on the methods of conversation analysis, discourse analysis, ethnomethodology, and narrative analysis with a focus on language.

the construction of reality and to consider the social use of language. These perspectives can be used together if it is needed.

Charmaz (2002) highlights that the history of sociology of medicine predominantly focuses on two key aspects: epidemiological studies and the analysis of experiences of illness. Epidemiological studies, characterized by their quantitative approach, which have been the cornerstone of medical research, aim to identify patterns of disease occurrence and risk factors within populations. On the other hand, the analysis of experiences of illness delves into the subjective, lived experiences of individuals. This qualitative inquiry into the illness experience elucidates the multifaceted dimensions of suffering, coping mechanisms, and the social context in which illness unfolds. There has been a wide use of qualitative methods in women's health research. According to Murray and Chamberlain (2000), it is possible to group women's health research under two headings as the first one positivist/ empiricist and the other group as contextualist/constructionist. The first group, positivist/empiricist research are composed of extensive surveys, content analysis etc. However, in the last decades there has been a radical break with this positivist science tradition (p.42). More researchers have started to conduct studies with contextualist and constructionist perspectives. As Conrad clearly puts, the application of qualitative methods in health research is better constructed by medical sociology and anthropology rather than it is studied by health psychology (1990, p. 1258). According to Radley, the main reason for this is the fact that sociology and anthropology have not been tied to medicine as strongly as psychology do (1999, p.16). While the medical approach has a concern to find out the connections between causes and effects which is established by natural science methods; the sociological view has a concern beyond cause and effect. Methods are techniques for gathering evidence; whereas methodology is "a theory and analysis of how research should proceed" (Harding, 1987, p.161). Epistemology is the "theory of knowledge of justificatory strategy" that underlies the methodology (Harding, 1987, p.162).

2.1. Why are Qualitative Methods More Needed in Women's Health Research?

In recent decades, feminist methodologies have become increasingly important in women's health research, as noted by scholars like Olesen et al. (1997). Qualitative

methods are particularly vital in women's health research because they allow for a deeper exploration of the complex, multifaceted nature of experiences. First, these methods enable researchers to approach the subjective accounts and individual experiences, which are often influenced by unique social and cultural contexts. Second, by providing space for contradictions in explanations, qualitative research acknowledges the non-linear, sometimes conflicting realities of participants. Third, the effect of social and cultural context is crucial, as it shapes these experiences in significant ways. Finally, the relationship between the researcher and participants plays a critical role, as it can shape the insights and understandings. Through these lenses, qualitative methods offer a more nuanced and comprehensive understanding for women's health, capturing the richness of their lived experiences. Moreover, research on women's health reveals several inadequacies. Adams et al. (2009) identify four main issues: the lack of large, representative samples; insufficient understanding of women's experiences and hazard perceptions; a gap in comparative research across cultures and time; and a shortage of studies on interactions with CAM practitioners (p. 237).

Qualitative approaches make it possible to describe and interpret subjective experiences of respondents. Considering subjective experiences in research is particularly important for women's health research due to two main reasons. The first reason is that in quantitative methods individual perspectives have been rendered invisible for the sake of reaching generalizations. When the results are explained by numbers and presented by statistical information; there is a risk of neglecting the complexities of the lives of respondents and making minority groups invisible. Not surprisingly, this mentality of quantitative generalization in academia has been challenged by Black feminists in the 1990s (Freedman, 1998; Brawley, 1994; Underwood, 1994; Staff, 1997). Freedman (1998) highlights the under-representation of Black American women in health research, which adversely affects their well-being and perpetuates biases in medical practice and training. This under-representation limits the applicability of research findings and may result in ineffective or harmful treatments for diverse groups. Prever et al. (2023) note that biases related to sex and gender can affect research publication decisions, impacting the validity of findings and health outcomes for women. Kalidasan et al. (2022)

emphasize that while gender-referenced research is encouraged, implicit biases often undervalue women-focused studies, necessitating a more inclusive approach.

The second reason for the shift in approaching the subjective accounts of respondents is that health studies have been gendered and biased towards masculinity (Lupton, 2012). Historically "the majority of health research has been conducted by men" (Murray and Chamberlain, 2000, p.43) and the medical studies have focused predominantly on male bodies; namely, the respondents were chosen from male patients (Daugherty et al., 2017). These two creates gender bias since the female body and its functions cannot be fully observed, analyzed, and understood. When data is collected exclusively from male respondents and the results are interpreted without considering female patients, it indicates that the reference point for health and illness has been gendered. A specific example for this situation is coronary heart disease studies. In 1985, a Public Health Service report on women's health issues highlighted the lack of research focused on women's health concerns. The report discussed implicit gender bias, particularly in cardiovascular health, and argued that cardiologists' gender bias contributes to gender inequalities (Daugherty et al., 2017). This phenomenon was later termed as 'gender medicine'. As Regitz- Zagrosek and Gebhard expressly put:

> The term 'gender medicine' was first introduced in the late 1990s. Gender medicine is the study of how diseases differ between men and women in terms of prevention, clinical manifestation, diagnostic and therapeutic approaches, prognosis, psychosocial effects, and interactions with the health-care system. (2022, p. 237)

Moreover, the WHO considers gender bias and puts this term in their agenda as 'Gender Medicine'. It defines *Gender Medicine*, or *Gender-specific Medicine*, as the study of how biological differences based on sex and socioeconomic and cultural differences based on gender influence people's health. A growing body of epidemiological and clinical data reveals significant differences in the development and clinical signs of conditions that affect both men and women. Gender also accounts for major differences in access to healthcare (EpiCentro, 2021).

Secondly, qualitative research approaches, unlike quantitative methods, provide a space for analyzing health and illness within their social and cultural context. As

Radley (1999) indicates, the concepts of health and illness are not abstracted entities, indeed they occur in a broader context of living (p.27). Radley argues that "illness needs to be studied qualitatively" because "illness is not a stable entity" (1999, p.19). The context of specific spheres of life, for example work as a social realm, is an important variable to understand the experience of illness because illness does not only affect a person's private life but also it arises in other spheres of life (p.21). Therefore, the concept of illness cannot be approached as being a 'static' factor. Rather, there is a dialectical relationship between the illness and the person's life. His argument is that chronic illness colors people's lives. "The use of the word 'colors' refers to the way that everyday life is reflected through either the knowledge that one is ill, or the way that ordinary actions are affected by bodily limitations" (Radley, 1999, p.19). Social realms like the workplace or family, as well as people's relationship with themselves can be studied by qualitative approaches to reach a more elaborated account of the processes of illnesses. For example, post-natal depression is being evaluated within the context of women's relationship with themselves, relationship to others, and to cultural and structural opportunities by Mauthner (1998). Mauthner's 'relational view' goes parallel to Radley's argument. The social and cultural context construct the experiences of people as well as the social context is being constructed by those experiences. Therefore, social, and cultural context need to be reflected and involved in research.

Thirdly, quantitative research methods have failed to demonstrate the contradictions of people's ideas, beliefs, and actions. The results of quantitative research cannot demonstrate the inconsistencies of the participants' views and realities since the main point is to reach generalized results. On the other hand, qualitative methods provide variabilities and inconsistencies rather than generalizations. For example, Bransen's article (1992), "Has menstruation been medicalized? Or will it never happen...", deals with different explanations of women about their menstruation and its role in their lives. Bransen has been critical to medicalization theory which suggests that medical discourse indoctrinates and dominates the female body. In her research, Bransen suggests that women do not simply obey the medical power and are manipulated by biomedical technology. Indeed, as her study shows women construct

their own ideas about menstruation.[52] Contrary to the medicalization theory's assumptions, this study shows that there is a plurality in women's accounts of menstruation. Such studies argue that meanings are not absolute. Multiple meanings can be possible and they are contextual and often contradictory (Malson, 2000, p. 369; see Wilkinson, 2000; Woollett and Marshall, 2000).

Fourtly, according to Murray and Chamberlain (2000) "whereas the aim of the quantitative researcher is to maintain control, the qualitative researcher is much more flexible" (p.47). Since the researcher has a predetermined design for collecting data in the quantitative setting, the researcher needs to maintain full control over the data collection and analysis process. There is no room for the participants to contribute to the research process other than answering the questionnaires. Therefore, the participants have only one choice to obey the researcher's design in which the participants' ideas or perceptions are not included in the design. On the other hand, qualitative research methods provide a space for the research participants to articulate their opinions; they are more likely to contribute with their ideas, perceptions, and articulations to the research design. Qualitative data collection strategy does not aim to strictly limit the participants to choose over the designed scale. To understand the differences between these two approaches of collecting data, we need to consider that the power in social relationships applies to the relationship dynamics between the researcher and the person under study. Nevertheless, the power dynamics between the researcher and the 'researched' is challenged by feminist ethnographers and reflexive anthropology methodology.

Elaine Lawless (1993) rejects the hierarchy that puts the researcher at the top. According to her stance, the research process should include the 'researched' as a participant of the study. Although there are difficulties in doing so in terms of time management, requiring a lot of labor for writing, evaluating feedback, and editing, Lawless posits this method worthy of applying to blur the distinction between the researcher and the 'researched' and the hierarchy between them (1993, p. 285). Her contribution is significant to challenge mainstream approaches by questioning the

52 She finds out that women explain the role of menstruation in their lives in three different genres: emancipation genre, natural genre, and the objective genre.

issue of power. As Altheide and Johnson (2011) point out, the discussions of methodological concerns have expanded and spread to a variety of other disciplines. While many methodological discussions previously attracted only a small number of anthropologists and sociologists, there has been a shift in the concerns of researchers from other disciplines such as pedagogy, gender studies, health sciences and others (p.581). Researcher-participant encounter is one of the main themes discussed within feminist research methodology through pointing to the power imbalances along with the importance of listening to women's voices and experiences. Beckman (2014) also directs attention to power imbalances in research methodology. When the researcher is perceived as the equal collaborator of the study as well as the researched people, the field starts to tell a more comprehensive story. Moreover, in action research projects, the focus is on the shared concerns of researchers and participants, aiming for desired results and change. Malterud and Hollnagel (1998) use an equal collaboration approach in their study on women's health resources, encouraging women to recognize their strengths and agency in their well-being. This method empowers participants by valuing their self-assessments, challenges the researcher's dominant position, and empowers participants to voice their concerns. Mishler (1991) critiques traditional interviewing for its power imbalance and advocates for respondent empowerment.

In Turkish context, research on women's reproductive health has largely been conducted within medicine and nursing (Ataman et al., 2019; Balkan et al., 2022; Erbil et al., 2012; Özkan et al., 2018), with fewer sociological studies (Cindoğlu & Sayan-Cengiz, 2010; Alkan et al., 2021; Gedik & Pehlivanlı, 2022). There is a notable lack of sociological research on women's health and alternative treatments. Given the increasing interest in CAM, as highlighted in the WHO's health plan, this study aims to fill this gap by examining the interplay between CAM and conventional medicine in women's reproductive health.

This thesis employs a feminist methodological approach to explore women's experiences with menstruation-related conditions, focusing on recovery efforts, treatment challenges, risk factors associated with alternative healing methods, and the potential for healing. To achieve this, I use qualitative methods, primarily

gathering data through semi-structured in-depth interviews and participatory observation. My fieldwork, which spanned over two years with intervals, is grounded in the principles of feminist methodology, emphasizing the importance of centering women's experiences, particularly in the context of health research where the male body has often been generalized as the standard for illness experiences. This approach is crucial in addressing women's reproductive health, which demands not only statistical analysis but also a deep engagement with experiential insights. By prioritizing and making visible women's perspectives, this research aims to contribute to the sociology field in Turkey, particularly in understanding women's interactions with biomedicine and TCAM.

2.1.1. A Radical Feminist Perspective on Reproductive Health: Challenging Conventional Narratives

My thesis adopts a radical feminist stance on women's reproduction, challenging the common view that prioritizes population control or fertility over the intrinsic value of reproductive health. It argues against the of women's reproductive organs and capacities, emphasizing their essential role in women's overall well-being and autonomy. By tracing the principles of the reproductive justice framework, this thesis contributes to critical scholarship on reproductive health across disciplines. As Morison (2021, p. 180) notes, in the context of neoliberal capitalism and growing reproductive oppression, the need for such work is more pressing than ever. Historically, sociological studies in the 1970s and 1980s associated women's health primarily with reproductive biology, focusing on services related to childbirth, contraception, abortion, and infertility, while neglecting other aspects of women's health (Doyal, 1995). Social sciences literature typically employs two analytical frameworks concerning reproductive health: one examines social-structural factors like socioeconomic status and access to healthcare, while the other focuses on reproductive rights within public health (Wang & Pillai, 2001, p. 232).

While acknowledging the importance of existing research, this thesis critically appraises these conventional perspectives. It also addresses the limited attention given to menstruation, which is often surrounded by stigma and embarrassment

(Olson et al., 2022; Bobel & Fahs, 2020). This thesis uses a radical feminist framework to reframe women's reproductive health as central to their well-being and autonomy, challenging conventional approaches that prioritize demographic goals over women's holistic health.

2.2. Field Study

Altheide and Johnson (2011) argue that:

> A more encompassing view of the ethnographic enterprise would take into account the process by which the ethnography occurred, which must be clearly delineated, including accounts of the interaction between the context, researcher, methods, setting, and actors. The broad term that we offered, "analytic realism," is based on the view that the social world is an interpreted world, not a literal world, always under symbolic construction (even deconstruction!). We can also apply this perspective to understand how situations in everyday life are informed by social contexts and uses of evidence. This application illuminates the process by which evidence is constituted. (p.586)

Altheide and Johnson (2011) argue that ethnography should account for the process by which it is conducted, emphasizing the interaction between the context, researcher, methods, setting, and participants. They introduce the concept of "analytic realism," which views the social world as an interpreted, symbolically constructed reality. This perspective helps us understand how social contexts shape everyday situations and the constitution of evidence (p. 586). Building on their approach, I agree that meaning is constructed through interaction, making all knowledge contextual and partial. There is an interplay between the observer, the observed, the setting, the audience, and the text. They (1994) stress the importance of presenting lived experiences authentically and making tacit knowledge visible, urging researchers to explain how this knowledge was uncovered. They also highlight the need for transparency in data collection methods and the acknowledgment that all knowledge is produced from a specific perspective. Following their emphasis on presenting lived experiences and revealing tacit knowledge, I will outline my epistemological stance in this research.

What a researcher regards as knowledge (evidence of things) in the social world brings the question of epistemology. As Jennifer Mason (2002) clarifies that

epistemological questions are different from the questions about how to collect data. "Epistemology is, literally, your theory of knowledge," so it concerns the principles by which a researcher "decides whether and how social phenomena can be known and how knowledge can be demonstrated" (Mason, 2002, p.16). Considering this explanation, my research topic is suggesting that distinctive dimensions of the social world such as perceptions, thoughts and experiences of women are knowable. In other words, this position suggests that it is possible to gather and 'generate' knowledge about these perceptions, thoughts, and experiences. I will do research for this end as Mason states that "your epistemology helps you to generate knowledge and explanations about the ontological courses, meanings" (p.16).

Mason (2002) argues that "data sources are those places or phenomena from or through which you believe data can be generated" (p. 51). In line with this, I view women as my primary data sources, recognizing that people are repositories of knowledge, experiences, and perceptions. Mason emphasizes that data is not something that exists "out there," ready to be collected independently of our interpretations as researchers (p. 51). She advocates for the term 'data generation' rather than 'collection' to reflect the active role of the researcher. This perspective aligns with my methodological stance in two key ways: first, social reality is not simply waiting to be collected; second, the researcher is not a neutral observer but actively generates data through a creative process. Thus, qualitative research is a "critical, yet productive and creative way of thinking and doing" (p. 4). The researcher actively shapes knowledge based on specific principles and methods, rather than simply "finding data that already exist." The task is to strategize how to generate data from selected sources. Thus, the method goes beyond mere data collection; it involves a process of intellectual, analytical, and interpretive activities (p. 52).

This will be followed by a detailed discussion on 2.2.1.Entering the Field and Establishing Rapport, where I will explain how I built trust with participants. Next, in 2.2.2.Generating Data and Conducting Interviews, I will discuss my data collection methods and the nuances of interviewing. I will present the process of recording of interviews and data analysis in the section 2.2.3. Recording of

Interviews and Data analysis. Later, in the section 2.2.4. Reflexivity in Research: My Positionality, I will discuss how I handle reflexivity and the sensitive nature of the fieldwork. In the section 2.2.5. Introducing Participants, I will present my interview interlocutors in detail, providing insights into their backgrounds and perspectives. Later, I will deal with ethical issues in the section 2.3. Ethical Concerns, and I will close up the chapter by discussing some limits of the research process in the section 2.4. Limits of the Research.

2.2.1. Entering the Field and Establishing Rapport

The field as well as the topic have been transformed and organized in the research process by the help of the respondents' opinions, questions, and problems. With a conscious positioning, I am critical to locating the researcher as the 'knowing subject' who has an 'objective stance' towards the study and having 'distance' to the 'researched' people; namely, the interlocutors of the research. With the same principle, I am critical to position human participants as the 'object' of the research. Therefore, I did not position the women who have involved in my field as the object of the research[53]. Rather, in every step of the fieldwork, the participants have been a collective contributor of the study.

Establishing a strong rapport and preventing the risk of instrumentalization of women are paramount priorities for me. For this reason, I took great care before sending out invitations to potential interview participants. For instance, knowing a bit about their reproductive health issues but wanting to gauge their comfort level in discussing them, I initially introduced myself and my research study, then inquired whether she felt it was appropriate to contribute to a social research project within this context. I also involved myself in my participants' everyday lives since with some of them we have built friendship. Also, I was engaged in some of the participants' everyday life events and psychological and spiritual states. With some of the participants, we spent time together in yoga and meditation retreat camps[54];

53 The split between subject and object positions have been challenged by many scholars, especially by feminist researchers (Pini, 2003).

54 In 2018, I attended a 200-hour yoga teacher training: YogANA Yoga School, Yoga Alliance RYS-200 Certified Training. This 6-month training included a yoga program specifically focused on

and spent time together in public spaces for dinner or having drinks. With some of the participants, we have joined the same training, for example Women's Healing Arts Training[55], Mysterious Femininity Programme[56]. Therefore, we become 'classmates' who learn together and who practice the same exercises for a certain period. Moreover, we developed a sisterhood over a period of 2-3 years which were quite effective for building rapport in a very natural manner.

2.2.2. Generating Data and Interviews

Since perceptions of women are crucial for this study, qualitative research techniques were used to gather first-hand data, and this led the research to follow semi-structured in-depth interviews in the field (Davies, 2007) and I utilized feminist methodology methods and techniques for every step of the research process. Different methods were used in the data generation process. Before conducting the interviews,[57] A literature review was carried out between June 2019 and December 2020 that assessed such previous scientific literature as academic articles and theses, which were reviewed together with research project documents. However, the literature review of my thesis evolved during the fieldwork process, shaped by the data I collected. As Charmaz (2006) explains, the literature review is not static; it is

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women's health and it is only open to women participation. The title of this training reflected its content: YogANA. This title can be translated as 'Yogi-MOTHER'. I can say that the fieldwork of this thesis naturally started through the meeting with the women I met during this training process. Even though I did not have a one-on-one interview with any woman from that training, the conversations we had during the process and our observations over the past 6 years were information that contributed to my fieldwork. For details about the training see https://www.yoga-ana.com/

55 Women's Healing Arts Training. See for details: https://www.embodiedhealing.co/medicine-woman-immersion

56 Mysterious Femininity Instructor Training Program (in Turkish: Gizemli Dişilik Programı) is designed to explore and rediscover feminine virtues and empower women through ancient techniques and wisdom. It covers various topics related to feminine health, energy transformation, spiritual teachings, and leadership, aiming to create a community of empowered women who can share their knowledge and healing abilities. Participants will undergo a comprehensive journey of self-discovery and learning, with the ultimate goal of becoming instructors who can guide others in embracing their feminine power and achieving holistic well-being. For details see: https://www.gizemlidisilik.com/hakkinda/egitim-seminerler/gizemli-disilik-1-egitmenlik-programi/

57 I get inspired by the fieldwork of Emily Martin's research about the cultural analysis of reproduction. Therefore, I refer her interview questions while preparing my semi-structured in-depth plan. For details see: Martin, E. (2003). The woman in the body a cultural analysis of reproduction; with a new introduction. Beacon Press.

revisited and transformed as new insights emerge from the data, allowing the researcher to refine and deepen their theoretical framework.

An initial pilot research was conducted with 5 respondents who were willing to participate in the first stage of the research during 2019. This pilot research was conducted especially for exploration how in-depth interviews can provide meaningful explanation for the research questions. In this phase, the research questions are evaluated in this respect, later the field research was launched at the end of 2021, with some delays due to the Covid-19 pandemic.

For the sample selection, I considered:

- Target Population: Women who have experienced reproductive health problems (e.g., endometriosis, PCOS, infertility, etc.).
- Sampling Method: Purposive sampling to select participants who have used both biomedical and TCAM approaches.
- Sample Size: 15-25 participants to ensure a range of perspectives.

Data Collection Methods: I used one-to-one in-depth interview techniques while collecting further observational data during the fieldwork.

1-In-depth Interviews:

a) Semi-structured format to allow for flexibility while covering key topics.
b) Key Topics: Personal health history, experiences with biomedical treatments, experiences with TCAM, reasons for choosing TCAM, perceptions of effectiveness, and overall health and well-being.

2-Participant Observation:

a) Observing interactions in TCAM settings (e.g., clinics, therapy sessions) to gain insights into the practice environment and patient-practitioner dynamics.
b) Observing in women-only places to explore the discussed or shared topics about reproductive health discussions to explore shared experiences and collective perceptions.

I followed the principles of intensive interviewing using Charmaz's approach. Intensive interviewing has been a valuable method for gathering data. It enables an

in-depth exploration of a particular topic or experience through a 'directed conversation' between the interviewer and the participant (Charmaz, 2006, p. 25; see also Lofland & Lofland, 1984). To initiate the interview process, several broad, open-ended questions were designed as a starting point. These were subsequently refined to invite more detailed discussion on the topic. By formulating open-ended and non-judgmental questions[58], I aimed to foster an environment suitable to the emergence of unanticipated insights and narratives. This approach was intended to encourage participants to share their experiences and perspectives in a manner that was both spontaneous and authentic (Charmaz, 2006). I facilitated the conversation by asking follow-up questions such as "Could you elaborate on that?" or "Can you provide an example?" to encourage a smooth and detailed narrative flow. During these interviews, I aimed to understand the participant's perspectives, inviting them to describe and reflect upon their experiences in ways that go beyond everyday conversations (Charmaz, 2006, p. 25).

A total of 18 interviews were conducted with women from different cities between November 2021 and March 2023, with each interview lasting from 1,5 hours to 3 hours. Some interviews are done in two successive meetings. Reaching out to participants was primarily facilitated through my involvement in traditional and alternative medicine social networks. Additionally, the snowball sampling method was employed to reach potential interview participants (Storey & Scheyvens, 2003), as having a trusted point of reference was crucial for building trust among the participants.

I attended workshops, participated in training sessions, and became an active member of the community. By establishing rapport and building friendships with many of the women before discussing my thesis research, I was able to create a foundation of trust that significantly enhanced the quality of the interactions[59].

[58] Following Charmaz's method, I was aware of the importance of doing interviews with open-ended and non-judgmental questions in order to encourage women to generate their story.

59 Cotterill (1992) emphasizes that the subjective experience of women researchers is a vital and multifaceted aspect of feminist research. It influences how researchers engage with their participants, the data they collect, and the interpretations they make. From the beginning of the fieldwork, this has been in my mind, directing every step of me in my interactions in my field.

The subjective experience of women researchers holds profound significance in the realm of knowledge production. Cotterill (1992) emphasizes that "putting the subjective in the knowledge" is an integral part of feminist research. By acknowledging and embracing the subjective experiences of women researchers, we gain a richer and more nuanced understanding of the social world. This approach recognizes that knowledge is not something that exists objectively but rather is constructed through our interactions and experiences. Therefore, the personal relations that develop between researchers and their participants can be a source of both strength and vulnerability.

On the one hand, these relationships can create a sense of trust and rapport that facilitates open and honest communication. Women participants may feel more comfortable sharing their experiences with a researcher they perceive as understanding and supportive. This can lead to the generation of richer and more detailed data. On the other hand, personal relations can also introduce complexities and challenges.

To complement these interviews, online platforms in Turkey, including regular media websites, as well as Facebook and Instagram pages, were selected for observation and evaluation. These platforms offered rich examples of women's experiences, particularly within personal story-sharing groups focused on the menstrual cycle, PCOS support groups, womb sciences, and women circle practices. I began by following relevant pages on Facebook and Instagram, consistently monitoring which issues were gaining prominence in these online communities.

This combination of methods allowed for a comprehensive understanding of the matter. In addition to that, the third phase of the study involved a participant-observation approach as I have visited many traditional, complementary, and alternative practitioners for the recovery process of my own reproductive health problems. Moreover, between November 2018- July 2023 I attended many womb healing sessions, meditation retreats, women circles, yoga camps which had provided me with an invaluable environment to observe similar minded women on their healing journey.

2.2.3. Recording of Interviews and Data analysis

The interviews[60] were conducted with the informed consent of the interviewees and recorded digitally. The duration of the interviews exceeded expectations except one interview. Most of the interviews took around 2-3 hours and after the record we continued off the record conversations. I may attribute these long conversations to the enthusiastic participation of the interviewees and the profound nature of the experiences they wished to share. The enthusiasm of the interviewees was crucial for the thesis, as it not only highlighted their sense of empowerment and agency, which aligns with the feminist methodological approach, but also underscored the importance of discussing the topic.

The effectiveness of an analysis depends on a comprehensive understanding of the data; this requires close examination, reading and re-reading. The interviews were audio-taped and transcribed. Each interview was carefully transcribed through repeated listening, a time-intensive process. At first, I examined the transcriptions by reading without coding. In the process of fieldwork, I did the first coding and continued the interviews, however new codes were added or removed during the field work, and I had to reorganize them. The codes were thereafter compared and categorized. The first-hand analysis of the transcriptions was conducted parallel to the interview process, in order to collect and interpret data, and identify emerging themes for further analysis (Glaser and Strauss, 1968; Strauss and Corbin, 1990). The data collection phase of the research was completed in May 2023. All the interview transcription texts were then printed and analyzed for themes and codes in alignment with the research questions. Coding involved interpreting the data to identify themes, patterns, and regularities, resulting in a comprehensive list of codes. Excerpts from each interview were then categorized under these codes, with a final review conducted to exclude unnecessary information and establish sub-codes. Subsequently, the interviews were prepared for interpretation and reporting. Although I did the coding by hand, during the final phase of the analysis, I employed qualitative analysis software, MAXQDA, to help me through this process.

[60] For the interview questions please see Appendix D: Questions of in-depth interviews in Turkish and Appendix E for English.

I used thematic analysis for identifying and coding themes related to the reasons for choosing TCAM, as well as the experiences and perceptions of health and illness with both biomedical and TCAM treatments. Then, comparative analysis was used to compare and contrast these experiences and perceptions, examining how they align with or challenge the biomedical and BPS models. As operational definitions I will briefly clarify biomedical and BPS models and TCAM methods. The biomedical model focuses on the physical and biological aspects of disease and illness, characterized by standardized treatments. In contrast, the BPS model considers the complex interplay between biological, psychological, and social factors in health and illness. TCAM methods encompass acupuncture, herbal medicine, homeopathy, and mind-body interventions etc.

2.2.4. Reflexivity in Research: My Positionality

> "Hindsight has enabled us to understand and articulate how our doctoral research was the product of our academic and personal biographies."[61]

Mauthner and Doucet (2003), makes clear that a doctoral work is a product of both academic and personal biographies. I totally agree with their assertion, as my thesis topic, the extensive six-year research process, and intensive fieldwork are deeply rooted in both my academic background and personal experiences. Qualitative researchers often draw valuable insights from their own lives, as Altheide and Johnson (1994, 2011) emphasize the significance of personal experience and tacit knowledge in qualitative research. They argue that these insights often emerge from the researcher's own experiences. They also note that qualitative research values findings from small samples, including single-case studies, but stresses the importance of understanding how these cases were selected and considering alternative cases. The goal of qualitative research is to understand how experiences are structured and organized. I also resonate with Reinharz's (1992) perspective that "starting from one's own experience is an idea that developed in reaction to androcentric social science" (p. 261). Beginning with one's own experiences offers a

61 They discuss reflexivity's role in qualitative data analysis by addressing its difficulties in practice drawing on their doctoral research experiences. See: Mauthner, N., & Doucet, A. (2003). Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis. Sociology, 37, 413-431.

more inclusive and nuanced understanding of social phenomena, challenging traditional androcentric perspectives in social science research.

In this section, I will explore how my personal experiences intersect with my research on women's reproductive health, and the challenges of maintaining reflexivity throughout the process. Initially, during the research proposal phase, my plan was to explore how traditional medicine and alternative therapies have gained popularity in Türkiye over the past decade—a broader research question. My experiences with gynecologists[62] and the biomedical hospital system in Türkiye provided me with ideas and perspectives on the topic. Based on my observations, I hypothesized that the biomedical approach to women's reproductive health is problematic due to its inadequate solutions for issues such as premenstrual pain, PMS, endometriosis, menstrual pain, the over-medicalization of pregnancy.

As I began writing my thesis and reflecting on my research, I came to an important realization. Throughout the process, I became so deeply immersed in my work that the boundaries between my research and my personal life started to blur. I realized that it was impossible to separate myself—the researcher who both selected and lived the research topic—from the work itself. My life and research had become deeply intertwined.

Given the personal nature of my research topic, reflexivity became a crucial aspect of the process. My own experiences inevitably shaped the questions I asked, the interpretations I made, and the conclusions I drew. To maintain reflexivity, I consistently reflected on how my background and beliefs might influence the research outcomes. I engaged in critical self-reflection to ensure that my findings were not merely a reflection of my own views but were grounded in the data collected from participants. This ongoing reflexive practice allowed me to navigate the complex interplay between my personal experiences and the academic rigor required for the study, leading to a more balanced and insightful interpretation of the issue.

[62] For instance, the article series titled "Gynecologist Talks' provides an overview about clinical practices concerning obstetric violence in Turkey. Please see: https://kaosgl.org/gokkusagi-forumu-kose-yazisi/jinekoloji-ve-obstetrik-kritik-klinik-fragmanlar

However, I am facing the reality that talking about my own experience is not as easy as I thought. When I started writing the field chapter, I realized how I had fallen into the trap of assuming many of the experiences and stories I heard during fieldwork were "non-research." Some of the participant observations and activities that can be counted as action research had seemed as "excluded from research". I think this was a reflection of the legacy of positivism that was ingrained in my bones as a way of doing science. Primarily, I had to convince myself that the experiences I had in the field were valuable and that I needed to gather my own self-confidence to explain them. This realization was shocking for me, as I noticed that, despite successfully implementing a natural flow of feminist methodology in the field—a methodology I had strongly advocated from the start—I ended up 'filtering' these experiences during the thesis writing process. I had treated the in-depth interviews as my only data set. I struggled to convey the value, meaning, and scientific relevance of other methods, such as my observations, the events and trainings I participated in, the conversations I had, and the experiences with doctors and patients I encountered. As Nahya and Harmanşah (2017), the editors of the recently published book *Ethnographic Stories*, which compiles articles focused on the researcher's personal experiences, noted:

> The lack of a reflexivity tradition in Turkey; our inexperience in looking at ourselves as a part of the field; the fact that exemplary texts are very rare in Turkish and the shyness and modesty of the people of this geography in expressing themselves stood before us like a wall. We were also aware that it was difficult to confront. The sensitive and vulnerable situation that revealing one's identity, ideas, the ethical dilemmas s/he faced, and sometimes expressing one's political stance can put a scientist was undoubtedly beyond undue anxiety. (p.260)

Firstly, I struggled with writing in the initial phases of the thesis process due to my inexperience in viewing myself as an integral part of the field. To put it more clearly, in my previous experiences in field studies when I was working on a project or working as a researcher, my responsibilities were limited to those of an assistant or field researcher. However, for doctoral research, the researcher had all the initiative in every stage, down to the smallest detail. This full engagement made it challenging to view myself as a part of the fieldwork. Consequently, it was difficult to balance

my dual roles as both a participant and a researcher, observing the field while simultaneously positioning myself to write the report.

One of the reasons I struggled with writing can be attributed to my cultural heritage. The "timidity and modesty in expressing oneself" (Nahya & Harmanşah, 2017), characteristic of the culture I grew up in, manifested in my own experience as well. I often found myself questioning, "Do I really know anything worth sharing?" This self-doubt began to hinder my ability to express what I knew. Additionally, confronting and revealing my health issues was particularly challenging. It is not easy to openly express my identity, my stance, and the dilemmas I face. Specifically, when it came to my thesis topic, clearly stating the health problems I experienced and my political stance felt like an act of exposing myself completely. However, it was somewhat reassuring to realize that I was not alone in these feelings.

Furthermore, the reflexive approach to research highlights the subjective nature of the process, emphasizing the importance of recognizing who we are (or who we believe we are) in the research and how our personal circumstances influence our work. As George Spindler noted, "all ethnographies are partly personal documents, balanced by efforts at objectivity" (1970, p. vi). While some social scientists continue to reject the subjective dimension of scientific research, there is now a broader acceptance of the necessity of reflexive texts. Haraway (1988) offers a strong reminder that, as a woman/researcher/patient, "location is about vulnerability; location resists the politics of closure, the finality" (p. 590).

2.2.5. Introducing Participants

The participants in this study are educated, middle-class, professional women between the ages of 37 and 61[63], all residing in urban areas of Türkiye. They have higher education degrees, ranging from bachelor's to PhDs, and have experienced or are currently dealing with women's reproductive health issues. In their treatment

[63] While all participants are adults aged 25 or older, age was not considered a primary factor in the analysis. "No statistically significant difference was found in attitudes toward traditional and complementary medicine according to age ($p = 0.127$)" (Köse et al, 2018, p.732).

processes, they have chosen to explore complementary, alternative, or traditional methods rather than relying solely on modern medicine.

I conducted 5 preliminary interviews as part of the pre-field study, followed by 18 in-depth interviews. Table 1 presents the basic socio-demographic information of the participants.

Table 2. Participants Basic Socio-Demographic Information

	Name	Age	Marital Status	Has child	City	Former Occupation	Current Occupation
1	Gönül	52	Single	no	Muğla	Civil Engineer	Certified Breathing Coach
2	Jale	43	Married	1 dau. 2 y. o.	Ankara	English Teacher	Certified Breathing Coach
3	Şükran	50	Single	no	İstanbul	Senior Bank Manager	same
4	Nüzhet	39	Single	no	Ankara	Mechanical Engineer	same
5	Hayrünnisa	37	Single	no	İstanbul	Drug distributor	Drug dist. & Women Circle Facilitator
6	Hicran	38	Single	no	Ankara	Academic Scholar & Midwife	same
7	Aysel	40	Married	1 dau. & 1 son	İstanbul	Phd candidate & Nurse	same
8	Safiye	39	Married	1 dau. 8 y. o.	İstanbul	Medical Doctor	Medical Doctor & Functional doctor & Ayurveda

Table 2. (continued)

9	Nuran	61	Married	1 dau. 27 y. o.	İstanbul	Industrial Engineer (retired)	Jewelry Designer
10	Tijen	45	Single	no	Muğla	HR Talent & Leadership Development Specialist	HR Specialist&Yoga Teacher
11	Afet	45	Single	no	İstanbul	Business Administrator	Translator
12	Türkan	37	Divorced	1 son 5 y.o	Eskişehir	Academician in Political Science	Same job and Yoga teacher
13	Cahide	43	Married	1 dau. & 1 son	Trabzon	Former Banker	Face Yoga Teacher
14	Pakize	42	Married	1 dau. 9 y.o.	İzmir	Industrial Designer & Senior Product Designer	Co-Founder At A Coffee Company
15	Emine	41	Married	1 son 6 y.o.	İzmir	M.S. in social sciences, government official	Same job
16	Dilhan	39	Single	no	Antalya (Kaş) -recently moved to Bartın (Amasra)	political science and public admin. & former business owner	Painter & Marbling Artist

Table 2. (continued)

17	Nermin	46	Married	no	İstanbul (in city)& Balıkesir (in village)	Nurse M.S.	Business Owner in Women's Health Education Program (KSEP) & Educator
18	Leyla	43	Widow (She lost her husband because of lung cancer)	1 son 11 y.o.	İstanbul	Foreign Trade Manager	Business Owner & expert (She did an M.S. in sociology about women breast cancer patients)

The demographic information gathered for the thesis fieldwork reflects a diverse group of 18 women from various cities in Turkey including Ankara, Antalya, Balıkesir, Bartın, Eskişehir, İstanbul, İzmir, Muğla, and Trabzon. Their marital statuses vary, including single, married, divorced, and widowed, with several women having children ranging from toddlers to adults while others do not. Professionally, these women come from diverse backgrounds, including engineering, education, banking, healthcare, and academia. Several participants have transitioned from previous occupations to become certified breathing coaches, face yoga teacher, translators, holistic practitioner and entrepreneurs in areas like jewelry design, functional medicine, and women's health education.

At first glance the general reasons for women for starting TCAM use:

1. To relieve symptoms related to reproductive health conditions
2. To relieve symptoms related to other health conditions
3. To maintain physical health
4. To support treatment and decrease medical treatment side effects
5. They are influenced by the belief in TCAM treatments held by those around them

6. They are not satisfied with conventional medical treatments
7. Their medical doctor recommended that they try TCAM.

Respondents in the study have indicated that they have utilized at least one method from the various categories of TCAM, Table 5 presents the classification of CAM categories. Many have engaged in Alternative and Medical Systems (AMS), such as 14 women used acupuncture and 10 women engaged in homeopathy, to address their health concerns. Mind-Body Interventions (MBI) like relaxation techniques, imagery, yoga, meditation, spiritual healing/prayer, and hypnosis have also been popular choices among participants. All women have indicated they start to do relaxation body techniques, 16 women out of 18 indicated that they started to do yoga for the healing of their symptoms. Meditation has been used by half of the respondents, some have become more experienced in meditation by participating trainings or getting certified by attending long education programmes such as Hayrünnisa, Türkan, Gönül, Şükran, Safiye, Tijen; while some respondents such as Nuran, Afet, Pakize, Emine try to learn meditation by themselves by following youtube, instagram pages and attending yoga and meditation classes at their neighbourhood.

Table 3. The Classification of CAM Categories Based on the National Center for Complementary and Alternative Medicine (NCCAM). Taken from http://nccam.nih.gov/news/camsurvey_fs1.htm

CAM Category	Examples
Alternative and Medical Systems (AMS)	Acupuncture, Homeopathy
Mind-Body Interventions (MBI)	Relaxation Techniques, Imagery, Yoga, Meditation, Spiritual Healing/Prayer, Biofeedback, Hypnosis
Biologically Based Therapies (BBT)	Herbal Therapy, Dietary Supplements, Vaginal Spa,
Manipulative and Body-Based Methods (MBBM)	Massage Therapy, Exercise, Chiropractic, Osteopathy
Energy Therapies (ET)	Energy Healing, Reiki

Additionally, BBT, including herbal therapy, dietary supplements, and vaginal spa treatments, were frequently mentioned by the respondents. MBBM such as massage therapy, exercise, chiropractic, and osteopathy have been commonly practiced as well. Furthermore, several respondents have explored Energy Therapies, including energy healing and reiki, highlighting the diverse approaches individuals take towards managing their health and well-being. The table above representing the classification based on the NCCAM[64] classification. In addition to NCCAM classification, for the Turkish context traditional methods such as hacamat[65] (cupping) and leech therapy (sülük) have been indicated by the respondents.[66]

Table 4. Participants' Knowledge and Use of TCAM Methods ,arranged according to NCCAM classification,

Methods	*in Turkish*	Those who know	Those who use
Acupuncture	*Akupunktur*	All respondents	Gönül, Nüzhet, Şükran, Hayrünnisa, Türkan, Afet, Dilhan, Leyla, Tijen, Safiye

64 National Center for Complementary and Alternative Medicine. (2007). The use of complementary and alternative medicine in the United States. Retrieved January 2024, from http://nccam.nih.gov/news/camsurvey_fs1.htm

65 Chen et.al. (2016) defines the cupping method and its history as such: "Based on the systematic arrangement from two aspects of the development history in the world and the latest global research progress of cupping therapy, it is found that cupping therapy is not only a part of traditional Chinese medicine, but also the important constituent part of traditional medicine in various countries in the world. Cupping therapy had been recorded as early as in ancient Egypt, ancient Greece, ancient India and other regions, and has been widely used up to now. It has also spread to the United States, and modern developed countries in Europe, and has always been favored by the people around the world. Cupping therapy is the commonwealth of world traditional medicine" (2016). See Chen, B., Guo, Y., Chen, Z., & Shang, X. (2016). Cupping: The common wealth of world traditional medicine. World journal of acupuncture-moxibustion, 26, 1-13.

66 There have been traditionally applied methods such as medicinal leech therapy (sülük tedavisi) and cupping treatment (hacamat / bardak çekme) in this geography for ages. In the last decade, these traditional methods have undergone an institutionalization process. The Ministry of Health provides Cupping Courses for medical doctors; The Federation of Cupping was established in 2016; The Association of Cupping was established in 2014 and The Institute of Cupping was established in 2013 in Turkey. So many new courses have opened both for the medical doctors and for non-specialists who are interested in. so, apart from the traditional applicants of these methods, we see that there are official certificates provided due to the new legal regulation of traditional medicine.
http://gelenekseltipakademisi.com/saglik-bakanligi-hacamat-kursu/
http://hacamatcilarfederasyonu.net/
http://hacamatdernegi.org.tr/
http://hacamatenstitusu.com.tr/kurumsal/tarihce/

Table 4. (continued)

Aromatherapy	*Aromaterapi*	All respondents	All respondents
Ozone Therapy	*Ozon tedavisi*	Most of them	Türkan, Gönül, Safiye
Bioenergy	*Biyoenerji*	Few of them	Gönül, Dilhan, Pakize, Cahide,
Relaxation Techniques	*Gevşeme teknikleri*	All respondents	All respondents
Hydrotherapy/Spa	*Hidroterapi/kaplıca*	All respondents	All respondents
Cupping	*Hacamat*	All respondents	Gönül, Nüzhet, Şükran, Hayrünnisa, Türkan, Afet, Dilhan
Leech Therapy	*Sülük Terapisi*	All respondents	Gönül, Nüzhet, Şükran, Hayrünnisa, Türkan, Afet, Pakize
Hypnosis	*Hipnoz*	Few of them	Gönül, Şükran, Hayrünnisa, Türkan, Afet, Pakize
Prayer	*Dua/namaz*	Few of them	Dilhan, Hicran, Aysel, Türkan
Massage	*Masaj*	All respondents	All respondents
Reflexology	*Refleksoloji*	Few of them	Türkan, Nüzhet, Şükran
Painting, Music, Dance Therapy	*Resim, müzik,dans terapi*	All respondents	Dilhan, Gönül, Şükran, Hayrünnisa, Aysel, Nuran, Tijen, Türkan, Emine
Therapeutic Touch	*Teropatik dokunuş*	All respondents	All respondents
Yoga	*Yoga*	All respondents	All respondents except Nermin, Leyla,
Phytotherapy	*Fitoterapi*	All respondents	All respondents

Table 4. (continued)

Chiropractic	*Kayropraktik*	Few of them	Türkan, Şükran, Gönül
Osteopathy	*Osteopaati*	Few of them	Nüzhet, Hayrünnisa, Tijen
Energy Healing	*Enerji Şifacılığı*	Few of them	Şükran, Hayrünnisa, Afet, Safiye, Emine, Pakize,
Reiki	*Reiki*	Most of them	Aysel, Hicran, Afet, Nuran
Biofeedback	*Biyogeribildirim*	None	None

2.3. Ethical Concerns

While informed consent ensures participants understand the study's purpose and their rights; confidentiality principle protects participants' identities and personal health information. Prior to the interviews, I provided the respondents with comprehensive information regarding the purpose and content of the research, why I have chosen such a topic, and what my purpose is by doing this research. Additionally, I emphasized that all personal information would be kept confidential in accordance with the Law on the Protection of Personal Data (KVKK), and that specific personal attributes would not be disclosed. Consent for audio recording before the interviews was obtained from all participants.

My research have been approved by Human Research Ethics Committee (İnsan Araştırmaları Etik Kurulu / IAEK).[67] I have added the "Approval of the Ethics Committee" document in the appendix section, confirming that my research method and research questions comply with the ethical criteria.

In addition to these concerns, my research did not include any elements that threaten physical or mental health of women. I was always very careful not to be a source of

67 My research was approved with Protocol number 436-ODTU-2021 by the Human Research Ethics Committee (İnsan Araştırmaları Etik Kurulu / IAEK). See Appendix A.

stress for the participants. Some of the topics that we had undergone through the in-depth interviews might be emotionally heavy since they share very sensitive stories of their reproductive health, phases of womanhood and personal life. Therefore, as a researcher I was aware of the importance of coping with these situations, so I was mindful of the sensitive nature of reproductive health issues. Charmaz (2006) emphasizes a number of considerations and principles to keep in mind when conducting interviews on sensitive topics or with participants who may share painful experiences:

> Just as you may need to give special consideration to interviewing certain participants, many topics require special attention. Studying life disruptions or stigmatized behaviors may raise questions of being intrusive. Participants sometimes tell painful stories during the interview that they never imagined telling that may or may not pertain to your study. I follow several principles in such cases that may help you. First, I assume that participants' comfort level has higher priority than obtaining juicy data. Second, I pay close attention as to when to probe. Often, I just listen, particularly when the participant appears to be reexperiencing feelings in the described incident. Third, I try to understand the experience from the participant's view and to validate its significance to this person. Fourth, I slant ending questions toward positive responses to bring the interview to closure at a positive level. No interview should end abruptly after an interviewer has asked the most searching questions or when the participant is distressed. The rhythm and pace of the interview should bring the participant back to a normal conversational level before ending. (Charmaz, 2006, p.30)

This excerpt emphasizes prioritizing the respondents comfort over obtaining sensational data, being attentive to when to probe deeper, listening actively, and ending the interview on a positive note to ensure the respondents' well-being and most importantly maintain a respectful conversation. For the purpose of improving myself on how to deal with possible emotional difficulties in the process of interviews, I have contacted one of my feminist psychologist friends who is working at *The Foundation for Women's Solidarity*[68]. I shared the difficult case I had experienced and asked for the possible coping advice from her.

68 "The Foundation for Women's Solidarity is an independent women's organization that aims to combat all kinds of violence against women through women's solidarity. It establishes solidarity with women who are subjected to violence and works with feminist principles since its official establishment in 1993". The web page of the foundation is https://www.kadindayanismavakfi.org.tr/en/who-are-we/

During the interviews, there were moments when participants recalled sad memories from their past or the shame and fear they experienced during their first menstrual periods. As they recounted these emotional experiences, their voices often trembled, and some began to cry. In these instances of heightened emotional intensity, I focused all my attention on being fully present, ensuring that the environment felt safe and supportive, and holding space for the emotions to surface, dissolve, and transform.

To better navigate these sensitive moments, I sought advice from a feminist psychologist friend who has long worked in the areas of women's solidarity and empowerment. Additionally, I participated in a four-month training program on "Women's Healing Arts," which combined both theoretical knowledge and practical applications. This training included *women's circles*[69] where participants could safely share their life experiences in a supportive environment. Through active listening and holding space for one another, many women found the strength to open up about their vulnerable stories, past experiences, and sometimes traumatic issues. This training provided me with valuable skills in moderating discussions and creating a space where women could share their experiences openly and without fear.

One of my interlocutors disclosed that she had experienced sexual assault as an adult while discussing her health and illness, and she discussed her reproductive health problems in relation to the assault she had experienced. To maintain confidentiality, I will refrain from using even pseudonyms in this section. Confronting the assault and undergoing therapy were crucial parts of her healing journey, making it inevitable for her to address this topic. However, I sensed her hesitation to bring it up during our first interview. In our second meeting, she cautiously asked me questions and began to share her story, seemingly testing my reaction.

[69] A women's circle is a supportive and non-judgmental gathering where women share their experiences, stories, and insights. These circles aim to foster community, empowerment, and healing. They typically include practices like active listening, mindfulness, and emotional sharing, creating a safe space for women to express vulnerabilities, connect, and find mutual support. Rituals, meditation, and discussions on topics relevant to women's lives may also be incorporated. There is a recent book called "Women are Healing" which deals with the circle tradition of women (Telek & Albayrak, 2021). See Telek, F., & Albayrak, D. (2021). Kadınlar Şifadır. Doğan Novus.

In addition to the interview conducted with her for my thesis, I met with this interlocutor on two separate occasions in different settings. During a three-hour conversation focused entirely on the subject of sexual assault, she opened up about her experience. Although this discussion fell outside the direct scope of my thesis research, the rapport we had established made it clear that I should not leave her story unfinished. I provided her with the space to fully discuss her post-traumatic healing journey until she felt satisfied. Reflecting on her story and acknowledging the progress she had made and the challenging processes she had endured, we concluded the conversation with a sense of recognition of her positive transformation. She had turned a painful experience into an opportunity for healing and growth.

Another interlocutor shared that she had undergone surgery for vaginismus in her twenties, a situation she had kept hidden from her family and friends and continues to keep secret. I noticed that she seemed uncomfortable discussing the topic, often skirting around it during our conversation. She mentioned that she had her first sexual experience at what she considered the late age of 27 and subsequently avoided sexual activity for many years. Her disclosure felt more like an impulse to mention it rather than a desire to engage in deep analysis. She highlighted that she had to go through the surgery alone, noting that her then-boyfriend had abandoned her and offered no support before or after the operation. This was a psychologically challenging experience for her. Recognizing her reluctance to dwell on the subject, I refrained from asking for further details.

Two of the interlocutors shared that they had undergone abortions in their twenties, and both wished to keep this secret, as their husbands were unaware of it. They specifically mentioned that they chose not to have the procedure done at a state hospital, instead opting for a private doctor to avoid having their records documented. They were uncomfortable with the possibility that abortions performed at state hospitals might be documented and shared with relatives without their consent. During these conversations, I observed and sensed that they wanted to unburden themselves of these secrets. Telling their stories seemed to have a comforting effect on them. It appeared that they were able to express these deeply

held secrets because they felt safe, unjudged, and close to someone they trusted in a supportive environment.

Another sensitive situation arose when five of the interlocutors disclosed childhood trauma related to sexual abuse and exploitation. Each of them has actively addressed this issue at various stages of their adult lives. They have sought psychotherapy support and some have utilized TCAM methods to mitigate the impact of trauma and aid in their healing process. During these conversations, the women share their insights regarding potential connections between women's health issues and experiences of sexual abuse. Psychological effects such as shame, fear, urge to hide body, difficulty in forming connections with female identity, and embarrassment about being a woman due to childhood trauma were discussed. Participants highlighted how these psychological impacts can affect their reproductive health.[70]

In conclusion, my journey in navigating emotional complexities during interviews has been profoundly shaped by both personal initiative and external support. Recognizing the necessity to handle these sensitive moments with care, I sought guidance from a feminist psychologist friend working at *The Foundation for Women's Solidarity* and received valuable coping strategies. These insights were instrumental when participants shared painful memories or feelings of shame and fear, allowing me to create a safe and supportive environment during the interviews. Additionally, the training on "Women's Healing Arts"[71] further equipped me with skills to facilitate and hold space for women sharing their vulnerable stories. Through these experiences, and as a sociologist using feminist interview skills, I have learned the importance of active listening, emotional presence, and creating a safe space, enabling participants to navigate and transform their emotional experiences with dignity and support.

[70] Devroede's concept of a 'cloacal' way of thinking (p. 142) provides a tool for the exploration the relationship between early life abuses and the development of gastrointestinal tract and pelvic floor dysfunctions in patients (Devroede, 2000). In Chapter 4, I discuss this concept.

[71] Women's Healing Arts Training. The one that I participated is in Türkiye: https://gulenaypema.com/seminerler/kadin-bilgelik-sifa-sanati-prog-160-saat/ See for more details: https://www.embodiedhealing.co/medicine-woman-immersion

2.4. Limits of the Research

The limits of this research can be attributed to constraints in sampling and potential emotional bias at the initial stage of the study. First, the sampling limitations arise from the restricted access to participants, who were drawn from a specific social network or community. This could lead to a sample that is not fully representative of the broader population, as the participants share similar experiences, interests, or social connections. I reached out to most of the interviewees through my network and most of the interviews have been conducted after building up a close relationship with the participants. Apart from my circle, a few of the women I get in touch with were introduced to me through my friends or through snowball technique. Since I had become a part of a women circle community, it was easier to build rapport with women from this circle. For instance, during pandemic period, from 20 March 2020 till 10 January 2021, I was part of an Instagram community called "*Karuna Dayanışma ve Şefkat Ağı*"[72] (Karuna Solidarity and Compassion Network). I volunteered for teaching yoga and reflexology courses for women there, and in the meantime, we started to form close relationships with other women who had been following these courses. With some of them I had talked about their health problems and their healing journey and use of alternative therapies. In this respect, for some part the fieldwork, I did an *action-research*[73], in which I have not only received information from the participants, I also shared my knowledge with them. Some kind of information exchange took place in the process of field work, which is an important aspect in the feminist method.

Second, the limits to research concerns with the emotional bias stemming from strong personal emotions and experiences. In the initial stages of the research, I harbored considerable anger towards the contemporary medical "industry", towards the gynecologists who disregarded the perspectives of women, towards prejudiced medical research, and pharmaceutical corporations. I find it meaningful to

72 Karuna; A solidarity platform consisting of independent volunteers to ensure that people overcome their lives in a more loving, peaceful and trusting way while the society goes through a sensitive period in which we are struggling with the global epidemic.

73 As a challenge to the commodification of knowledge; I believe that it is very crucial to share the knowledge produced during the research process with the participants and the related people.

acknowledge these sentiments as they served to direct my focus towards the topic that I intend to explore within this study. At the same time, this emotional response also evoked a sense of helplessness alongside the ressentiment. I felt helpless and powerless, because in the very beginning of this research I was frustrated about whether there were solutions to "the unexplained"[74] menstrual issues faced by women. There were so many questions, practically as well as academically that I could not answer. During the course of this thesis research, I have experienced a personal transformation in which I have acquired a sense of empowerment devoid of feelings of anger or helplessness. Over a span of 6-7 years, I explored different methods to observe and engaged closely with women to collect and gain a multifaceted understanding of women's reproductive health. This collaborative process not only equipped me with an array of tools for addressing women's health issues, but also provided me with valuable sociological insights. Through the cultivation of bonds with the women who generously contributed to this study through in-depth interviews, a mutual exchange of knowledge and experiences catalyzed a shared sense of resilience and empowerment. While these emotions helped guide my research focus, they might also have influenced the way I approached my study, potentially have influences in how I interpreted data or engaged with participants. These limitations highlight the importance of reflexivity in qualitative research, where the researcher continually reflects on her own influence on the research process and strives to acknowledge any biases that may arise, which I mentioned previously in the section 2.3.5.

74 'Medically unexplained' means biomedically unexplained. Biomedically orientated clinics often lack biopsychosocial management protocols, resulting in unmet needs and potentially long, costly patient journeys. Examples include general practice, cardiology, neurology, and surgery for some pain presentations (Bolton, 2023, p. 7508; see for example Jadhakhan et al., 2019; Lenderink & Balkestein, 2019; Carson et al., 2003; Louw et al., 2017).

CHAPTER 3

THEORETICAL FRAME AND CONCEPTUAL TOOLS

This introductory section offers first an overview of the principal theoretical frameworks utilized in analyzing medicine, health, and illness in social sciences for a historical background. Spanning from the 1950s to the present day, there have been changing lenses within medical sociology and the sociology of health and illness. This section encompasses an overview on three dominant pivotal social theories elucidating their significance in shaping our understanding of the complicated interplay between medicine and society. So, in section 3.1. I will present functionalist, political economy and social constructionist perspectives in the field. Second, in the section 3.2., I will present the different medical models to health and illness as (1) biomedical model, and (2) BPS model. Biomedical model, which is the dominant approach in Western medicine, focuses primarily on biological factors in understanding health and illness; and BPS model, which emphasizes the interaction between physiological, psychological, and social factors in constructing health and illness with reference to George Libman Engel (1977). In Section 3.2.1.4., titled "The Body, Social World, Pain and Human Experience", I will discuss how understanding embodied experience can go beyond the mind-body dualism in health research. In the section, first I will present how Merleau-Ponty's phenomenological approach can be used to simultaneously explore the psychological and social dimensions of health and illness of an embodied experience, as an alternative to the biomedical model's view of mind and body as separate. Following this, I will discuss feminist scholars's attempts to unravel the social and cultural dimensions of the body, focusing on embodiment, identity, and the interaction between biology and culture in influencing bodily experiences. Later, I will continue with Chapter 3.3, where I discuss *The Evolution and Implementation of Family Medicine in Türkiye.* In this section, I will explore how FM has developed in Türkiye, the theories that have

shaped its foundation, and the practical issues faced during its implementation. Following this, in Chapter 3.4, I will focus on the *Integration of TCAM in Türkiye*. These sections are crucial for understanding the broader healthcare landscape in the country because they highlight the intersection of Western biomedical practices and alternative medical approaches. By examining both issues, I aim to show how different healthcare models coexist and interact, offering a comprehensive view of the challenges and opportunities within the Turkish healthcare system.

3.1. The Social Theoretical Perspectives in Health, Illness and Medicine

Early in its development, sociology of health and medicine were addressed through mainstream theories in the sense that sociologists extensively utilized established theories (Collyer & Scambler, 2015). This section explores the evolution of medical sociology, tracing its roots from functionalist theories to the rise of political economy perspectives and social constructionism. I will examine how these theoretical frameworks have shaped the understanding of health, illness, and the role of medicine in society.

A pivotal moment in the development of medical sociology occurred with the publication of Talcott Parsons' seminal work, *The Social System,* in 1951. Parsons's work served as an open call for sociologists to focus their research efforts on health-related issues. He offered a structural-functionalist analysis of health and medicine (Collyer & Scambler, 2015). The functionalist approach to the sociology of health and illness examines how various parts of society, including healthcare systems, contribute to the overall stability and functioning of society. It discusses the insights offered by functionalist theory in understanding the roles and functions of healthcare institutions within social frameworks. "Structural functionalism emphasized the macro-level social processes, structures, norms and values external to individuals that served to integrate them into the wider society and molded their behavior" (Collyer & Scambler, 2015, p.8). In this view, illness is seen as a potential state of social 'deviance' and considered an unnatural state of the body. Specifically, this refers to a deviation from accepted societal norms and expectations (see, for example, Durkheim, 1951). Because of the deviation of societal norms, functionalists

argue that people feel vulnerable due to illness such as feelings of stigmatization of shame. As a result, functionalists propose that the medical field should play a crucial role in regulating society by acting as a moral authority, distinguishing between what is considered acceptable behavior and what deviates from norms (Lupton, 2012, p.2). Structural functionalism prioritizes balance and agreement within a system. Later, this perspective faced criticism as Jordanova (1983) states, "An historical sociology of science and medicine needs to have a critical orientation towards its subject matter, to go beyond static description, to transcend the internal/ external dichotomy and to eschew mechanistic definitions of the kind derived from functionalism" (Jordanova, 1983, p.93). More specifically, the portrayal of individuals primarily as passive participants within broader social systems criticized by Symbolic Interactionists.[75] Within this approach, the primary scholars contributing to medical sociology were Anselm Strauss and Erving Goffman (see, for example, Strauss, 1957; Goffman, 1959, 1961, 1963; Becker et al., 1961; Davis 1963; Roth 1963; Strauss and Glaser, 1965; Freidson 1970).

One of the main criticisms towards functionalism came from the political economy perspective which is commonly known as conflict theory. In the following paragraphs, I will give a brief information about the political economy perspective and conflict theory in sociology of health. Conflict theory, influenced by the perspectives of Marx, posits that society is defined not by consensus, but by the conflicting interests of various groups (Collyer & Scambler, 2015, p. 9). Also known as critical structuralism, this theoretical approach was influential in the sociology of health and illness in the 1970s and early 1980s. This perspective in medical sociology views health not only as physical or emotional well-being but also as access to resources that sustain life at a satisfying level (Baer et al., 1986). According to political economists, marginalized individuals like the ill, elderly, or physically disabled are sidelined by society because they do not contribute to economic productivity. They argue that medicine, rather than reducing social

[75] In the 1960s symbolic interactionism gained popularity and became a commonly utilized approach. They argued that individuals, through their interactions and shared symbolic understandings, collaboratively shape social reality at a micro-level. This perspective posits that social reality is the result of the actions of interacting individuals who have agency to make choices, rather than being completely dictated by larger systemic forces and structures that limit their options (Collyer & Scambler, 2015, p.8).

inequalities, actually reinforces them, with modern healthcare under capitalism being viewed as inefficient, costly, and poorly regulated.[76]

Like functionalists, political economists view medicine as a moral force, used to define normality, punish deviance, and maintain social order. However, they see this power as harmful rather than beneficial and criticize the values of scientific medicine. Political economists suggest that Western medicine focuses too narrowly on physical factors, neglecting broader socioeconomic causes[77]. There are two main approaches within the political economy perspective: one seeks to improve medical services for the underprivileged, while the other questions the value of biomedicine itself, highlighting its role as a tool of social control[78] that reinforces racism and patriarchy. Both approaches critique medical knowledge for serving the interests of the ruling classes (Lupton, 2012, pp.6-7; see, for example, Waitzkin, 1983; McKinlay, 1984; Navarro 1986; Boston Women's Health Book Collective, 1973; Doyal, 1979).

Early sociological studies in health and medicine predominantly adhered to positivist values, aligning the field more closely with social medicine than with critical sociology during that period (Lupton, 2012, p. 2; see Mechanic, 1993). However, the

76 This perspective is supported by scholars who argue that the working classes are systematically disadvantaged within the healthcare system. "In their different ways, Waitzkin (1983), McKinlay (1984) and Navarro (1986) challenged the status quo by asserting that the working classes are systematically disadvantaged in relation to the social determinants of disease, the nature of healthcare systems, healthcare utilization and medical encounters" (Collyer & Scambler, 2015, p.9).

77 From the perspective of McKee (1988) these socioeconomic causes are elaborately linked to the outcomes of capitalist production. For instance, products such as heavily processed foods containing chemical additives, environmental pollution, high levels of stress, feelings of alienation, and occupational hazards are all manifestations of this capitalist system (Lupton, 2012).

78 Kilwein (1994) indicates that the concept of medicine serves as a tool for social control. Kilwein delves into the idea that medicine, beyond its role in treating illnesses, is utilized as a means of social regulation and influence. The main question is how medical practices, institutions, and interventions are wielded not only to address health concerns but also to enforce norms, behaviors, and power structures within society (Kilwein, 1994). The use of medicine as a social control tool has been approached from a Marxist perspective and, to a lesser extent, a Marxist feminist perspective. While Waitzkin (1983) holding a Marxist perspective and Oakley (1984), a Marxist feminist, made a similar point on social control in the sense that they have attributed the actions of the medical profession more broadly to satisfying the interests of capitalism (Waitzkin, 1983) and patriarchy (Oakley, 1984). Oakley's critical feminist viewpoint on motherhood and medicine examines the professional shifts and advancements in technology that led to the categorization of 'pregnancy' as a specific form of social conduct regulated by the medical field.

politics of the late 1960s began to challenge this alignment. "The radical politics of the late 1960s addressed itself to developing a critique of science and medicine and their privileged epistemological and social position" (Jordanova, 1983, p. 82). Lupton (2012), referencing Armstrong's Silence and Truth in Death and Dying, notes that throughout much of the history and development of medical sociology and the sociology of health and illness, the model of scientific medicine remained focused on a biological and anatomical conception of the body, largely unchallenged (p. 3). As a result, until the 1980s, medical sociology primarily operated within this framework, accepting it as the prevailing understanding of the human body.[79]

In the early 1980s, a significant shift occurred within medical sociology as social constructionism gained prominence, altering the field's theoretical and methodological orientation. According to Lupton (2012), the influence of functionalism and the political economy approach began to wane in the 1970s, while social constructionism continued to grow and evolve (p. 3). This perspective challenges the notion of universal truths, viewing knowledge as a product of power relations and social contexts. As such, knowledge is dynamic, shaped by discourses and practices within specific cultural settings, and understanding its formation becomes a key focus.[80] In the sociology of health and illness, the social constructionist perspective highlights the social dimensions of biomedicine, emphasizing the development of medical knowledge and practices among both professionals and the public. It underscores the role of social interactions in shaping

[79] In a similar way, the focus of medical anthropology has shifted over time. In the 1940s, studies centered on the magical aspects of medicine in non-European societies. By the 1960s, the relationship between culture, environment, and biology became a key area of inquiry. In the 1990s, attention turned to modern diseases like AIDS and women's health. In the 2000s, research began focusing on conditions such as diabetes, eating disorders, obesity, and the links between diet and disease (Kaplan, 2008, pp. 45-47). Postmodern developments have also encouraged a growing interest in health within social sciences. Additionally, alternative medicine practices in industrialized and capitalist Western societies have become a prominent topic (Gürsoy, 2005).

[80] Yet, in the social sciences there has been an increasing dominance of post structuralist and postmodernist analysis of issues surrounding the concept of bodily experience. This growing dominance poststructuralist analysis of bodily experience brought renewed intellectual interest to the field of the sociology of health and illness. These new interests also brought to the social constructionist perspective a previously neglected consideration of macro-level power relations issues, thus incorporating some of the concerns of the political economy perspective. So, incorporating political economy perspective with social constructionism is the perspective that was adopted by Lupton (2012).

health and illness experiences, advocating for cultural and social analyses. This approach challenges the objectivity of Western medicine's truth claims, arguing that they, like lay knowledge, are shaped by societal beliefs, values, and norms (Lupton, 2012; Collyer & Scambler, 2015). This perspective challenges the notion that Western medicine's truth claims are purely objective. Moreover, it highlights the role of social context in shaping medical knowledge and practices. This interdisciplinary effort has united scholars from sociology, anthropology, philosophy, and social history to critically explore the cultural foundations of Western medicine. As Jordanova (1983) argues, Western science is not an embodiment of absolute, value-free truth but is shaped by its social and cultural context. Scientific knowledge is influenced by societal beliefs, norms, and interests, making it essential to examine Western medicine within its social framework rather than assuming it offers objective, absolute truths.

The feminist movement has highlighted how medical and scientific knowledge can perpetuate power dynamics, often to the detriment of marginalized communities. Scholars within the social constructionist framework, though politically varied, agree that power stems from multiple sources beyond capitalism (Foucault, 1973; Haraway, 1985; Williams, 2006). As Lupton (2012) notes, the view of medicine as social control has evolved from seeing it as overtly oppressive to understanding it as producing knowledge that shifts across contexts. Medical power is not just institutional but is also internalized through socialization into accepted norms. This perspective allows for understanding illness, disease, and pain as culturally and socially mediated experiences.

3.2. Approaches to Health and Medicine: From Biomedical to Holistic Models

This section will begin by exploring different interpretations of the concept of health, then transition to a sociological perspective. One of the earliest and most enduring contributions to our understanding of health comes from Hippocrates, whose ideas continue to shape modern medical thought. In the 5th century BCE, the Hippocratic school marked a significant shift away from supernatural explanations of health. Known as the "Father of Modern Medicine," Hippocrates was the first to separate

Greek medicine from magical and religious beliefs (Badash et al., 2017). He defined health as a state of balance and harmony within the body, where all its constituents are in proper proportion and strength (Morgan et al., 1988). According to this view, well-being is maintained through this equilibrium, while imbalances result in illness and discomfort. He emphasized the importance of a balanced diet, physical activity, and environmental factors in maintaining this equilibrium.

For Hippocrates, health was not merely the absence of disease but rather a dynamic state of balance where the body's natural processes function optimally.[81] In essence, his approach underscores the intrinsic connection between balance, harmony, and well-being, emphasizing the importance of addressing imbalances to support overall health and vitality. To highlight the influence of the Hippocratic ideal on modern healthcare practices, a ceremony is held in which new doctors are required to swear adherence to specific ethical principles. The Hippocratic Oath[82], a prerequisite for obtaining a medical license in Greece, embodies the enduring principles of the Hippocratic ideal, such as professional integrity, compassion, and respect for human dignity (Kleisiaris et al., 2014). This philosophy, which emphasized the importance of a sound mind in a healthy body, laid the foundation for early medical practice.

However, as scientific advancements unveiled the complexities of cells, microorganisms, genes, and molecular structures, these foundational health concepts were refined and expanded. This progression led to the emergence of new definitions and approaches to health that built upon the original ideas of Hippocrates and Galen. Among these, the WHO's definition of health is often regarded as a cornerstone in modern health discussions (Badash et al., 2017). Established in 1948, this definition has been widely used by healthcare professionals for nearly seven decades. The WHO defines health as "a state of complete physical, mental, and social well-being,

[81] While the era of scientific medicine had not fully emerged during Hippocrates's time, his foundational understanding laid the groundwork for contemporary medical practices. His emphasis on the balance of bodily constituents and the impact of imbalances on health remains a cornerstone of medical philosophy, guiding approaches to diagnosis, treatment, and prevention in modern healthcare.

[82] The Hippocratic Oath is a long-standing tradition of ethical pledges made by physicians entering the medical profession. See: Wikimedia Foundation. (2024, June 6). Hippocratic oath. Wikipedia. https://en.wikipedia.org/wiki/Hippocratic_Oath

not merely the absence of infirmity or disease."[83] While this definition is broadly accepted within institutional medicine, it has faced significant criticism from philosophers of medicine and medical scientists (see, for example, Leonardi, 2018; Habersack & Luschin, 2013; Doll, 1992). Schramme (2023) suggests that the WHO's definition can be interpreted in two ways: as an ideal of perfect health, which is hypothetical and unattainable, or as holistic health, encompassing various aspects of well-being. In response to the perceived limitations of the WHO definition, several alternative definitions of health have been proposed.[84]

Setting aside these critiques of the WHO's definition, the institutionalization of biomedicine has led to fluctuating and varied methodologies for understanding health and illness (Lupton, 2012; Foucault, 1973; Illich, 1976). Two primary medical models differ significantly in their approaches to these concepts. On the one hand, there is the biomedical model, and on the other, the holistic model offers an alternative perspective (Morgan et al., 1988; Guttmacher, 1978; Gelfand, 1976). I will begin by examining the biomedical model's approach to health and disease(section 3.2.1.), then continue with the BPS model (3.2.).

The biomedical model, also known as allopathic medicine, is a conventional approach that focuses on treating symptoms and diseases primarily through medications or surgical interventions, though it may sometimes result in adverse effects. Allopathic medicine, also known as allopathy, is a term that was initially used in the 19th century by homeopaths to describe "heroic medicine"[85], which is the

[83] WHO (1948). Summary Reports on Proceedings Minutes and Final Acts of the International Health Conference held in New York from 19 June to 22 July 1946. World Health Organization, available from: https://apps.who.int/iris/handle/10665/85573

[84] The diverse perspectives highlight the ongoing search for more comprehensive and context-sensitive definitions of health. René Dubos, in "The Mirage of Health" (1959), defined good health as the condition best suited for individuals to reach their personal and social goals. Abraham Maslow, in "Towards a Psychology of Being" (1968), linked health to the fulfilment of needs in a hierarchical order: physical needs, safety, love and belonging, esteem, and self-actualization. Paul I. Ahmed, in "Toward a New Definition of Health: Psychosocial Dimensions" (1977), emphasized that health should be seen as a relative term, recognizing individual and societal circumstances and viewing health as a means to fulfil role obligations. Bircher, focusing on health economics, proposed updating the definition of health to a "dynamic state of well-being," considering a person's physical, mental, and social potential to meet life's demands.

[85] During the early 19th century, the medical practices in Europe and North America were sometimes called "heroic medicine" because of the extreme measures, such as bloodletting, employed to treat

forerunner of contemporary evidence-based medicine (Weatherall, 1996). In 2001, the WHO defined *allopathic medicine*, as referring "to the broad category of medical practice that is sometimes called Western medicine, biomedicine, scientific medicine, or modern medicine" (2001),[86] employing this terminology in a global study to distinguish Western medicine from traditional and alternative forms of medicine.

The second basic approach to health and illness is the holistic model. According to The American Holistic Health Association (AHHA), holistic medical approach emphasizes treating the whole person encompassing body, mind, and spirit.[87] This approach is a medical approach that envisions healing as an innate potential within the human body, which can be activated through stimuli directed at the body, mind, spirit, and emotions.[88] Through the integration of traditional and alternative therapies[89] holistic medicine aims to prevent and manage disease, and more significantly, foster optimal health and well-being. This perspective has been central to medical philosophy since ancient times. Hippocrates defined a physician as "someone who activates the natural healing potential within the patient". Ancient physicians also embraced the notion encapsulated in the phrase "*medicus curat, natura sanat,*"[90] meaning "the physician assists the body, nature heals".[91]

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diseases. Homeopaths used the term "allopath" to differentiate their approach from conventional medicine. For details see: https://en.wikipedia.org/wiki/Allopathic_medicine

86 https://iris.who.int/bitstream/handle/10665/42452/WHO_EDM_TRM_2001.2.pdf?sequence=1

87 Principles of Holistic Medicine. American Holistic Health Association. (n.d.). https://ahha.org/selfhelp-articles/principles-of-holistic-medicine/

88 Hippocrates, naturopathy, and the art of healing. Ebrary. (n.d.-a). https://ebrary.net/194040/health/hippocrates_naturopathy_healing

89 These may include traditional healing methods, herbal medicine, acupuncture, chiropractic care, homeopathy, naturopathy, and others.

90 "So, as long as the natural healing mechanism is guiding one's life, the person is alive. But when the natural healing force stops performing its function, no kind of drugs or surgery can heal a patient. This is why the Great Hippocrates said, "Physician treats but Nature heals."
For details, See: Hippocrates, naturopathy, and the art of healing. Ebrary. (n.d.). https://ebrary.net/194040/health/hippocrates_naturopathy_healing

91 In his famous statement, Hippocrates asserted that nature, not the physician or their remedies, is the true healer of diseases. This suggests that if the natural healing processes cease, neither doctors nor their medications can effectively intervene. Furthermore, it posits that humans possess an innate healing mechanism that safeguards us against stressors we commonly refer to as diseases.

According to the philosophy of holistic medicine, the human body is composed of interconnected systems, and if any part of these systems is not functioning properly, it is assumed that all other systems will be affected. Thus, the human body is seen not as a "complicated mechanical system," as modern medicine often assumes, but as a "complex adaptive system."[92] Consequently, humans are believed to be endowed with the potential to adapt to all internal and external (physical, emotional, or spiritual) stressors in a manner that maintains the body's balance (homeostasis). In the following section, I will delineate the biomedical model and holistic model to health and illness respectively, and I will specifically focus on the BPS model[93] as a holistic approach, which provides the theoretical conceptual framework of this research.

3.2.1. Biomedical Approach to Health and Illness

The Biomedical Model focuses primarily on biological factors, centering medical interventions on physiological aspects of health and illness. Traditionally, it emphasizes medical treatments while often neglecting psychological and social factors. Conventional medicine tends to narrowly address the physical causes of illness, frequently overlooking the broader socio-cultural influences on health experiences, healthcare access, and doctor-patient interactions.

In this thesis, I use *biomedicine* to refer to the Western scientific medical model. However, it's important to note that biomedicine is a complex term without a precise definition, despite its widespread use. Originating in eighteenth-century Europe, it gained prominence in the nineteenth century as a branch of biological sciences. It

[92] For a reference that supports the holistic medicine philosophy describing the human body as composed of interconnected systems and viewing it as a complex adaptive system, please refer to:
Paley, J., & Kernick, D. (2006). Complexity and the Healthcare Professions. In Complexity and Healthcare Organization: A View from the Street, essay, Radcliffe Publishing.
Paley, J. (2011). Complexity in health care: A rejoinder. Journal of Health Services Research & Policy, 16(1), 44–45. https://doi.org/10.1258/jhsrp.2010.01011
These sources discuss the concept of the human body as a complex adaptive system and the interconnected nature of its systems, aligning with the holistic medicine approach.

[93] The biopsychosocial medical model emphasizes the interaction between physiological, psychological, and social factors in constructing health and illness (Engel, 1977). Biopsychosocial approach, which embodies the Hippocratic aim of curing sometimes, healing often, and always consoling, possesses the characteristics of a holistic model.

evolved into the dominant force in medical knowledge and practice, replacing older methods with its emphasis on progress, empiricism, and rationalism (see Hardy, 2001; Baranov, 2008). Baranov's (2008) study provides a clear understanding of biomedicine as an analytical concept within the medical social sciences. As he explains:

> By the early decades of the twentieth century, having demonstrated its value as an effective tool for the diagnosis, treatment, and prevention of disease, Western scientific medicine had become singularly identified with biomedicine. The techniques and symbols of biomedicine (e.g., vaccinations, laboratory testing, and high-tech gadgetry) had captured the popular imagination of the West and its methods were associated with advanced, 'scientific' medical care. At the same time, as an emerging profit-generating venture, biomedicine was the source of fierce battles among physicians and between physicians and corporate interests. A unique combination of scientific-material, symbolic-cultural, and social institutional influences has thus shaped Western interpretations of biomedicine from its beginnings and through its ongoing formation. (p. 236)

According to the argument of Baranov (2008), biomedicine can be viewed through three interconnected ontological perspectives, each shaping how it is understood as a field. The first perspective sees it as the primary framework for modern medicine, as scientific- material. This orthodox empirical perspective posits biomedicine as the primary classifying and organizing framework for contemporary medicine, predicated on the fundamental concept that illness is a physical phenomenon resulting from damage to the body. The patient is interpreted as a passive recipient of medical research, with belief in progress, control over nature, utilitarianism, observation, measurement, and experimentation being central concepts. These ideas were reinforced by significant epistemological advancements grounded in empiricism and rationalism, which drew inspiration from Western developments like Galileo and Newton's investigative methods, leading to the standard approaches to ensuring accuracy and objectivity (Baranov, 2008, p. 238). Any departure from these rigorous empirical methods was seen as potentially introducing personal bias into the findings (see, for example, Hardy, 2001; Lane, 2001; Duffin 2010). The second perspective regards biomedicine as a symbolic-cultural practice, where its underlying ideologies are obscured by a surface appearance of professionalism and scientific

credibility. It is seen as wielding ideological power behind its scientific guise.[94] The third perspective takes a more critical stance, viewing it as a tool of social control, perpetuating, and reinforcing class divisions, power dynamics, and privilege. This perspective highlights the societal implications and power structures embedded within biomedicine (Hughes, 2015, p.448). Among the three perspectives, the scientific enterprise holds the greatest prevalence and dominance within Western societies. Emphasis on logic (see Duffin, 2010) and the concept of progress, which assumes that medical advances depict human progress have paved the way for establishment of medicine as a respectable profession (see Lane, 2001). To summarize, medical science operates on the principles of empirical evidence and logical reasoning, involving systematic observation, measurement, and experimentation on the subject under investigation.

3.2.1.1. Criticism to Biomedical Model: A Historical Bias in Medicine

The biomedical model is frequently criticized as leading to 'reductionism' and 'medico-centrism' as expert interpretations are seen as the basis for biological evidence (Armstrong, 1987). This approach limits the understanding of health to biological aspects, neglecting the complex interplay of social, cultural, and psychological factors that also impact well-being (Markovic et al., 2008; Johansson et al., 1999).

Similarly, Baszanger (1998) sheds light on how physicians prioritize different levels of explanation when diagnosing and treating patients. In her research, she observed a hierarchy of explanation levels among physicians. At the top of this hierarchy is cellular pathology, which refers to the physical and biological processes at the cellular level in the body such as tissue damage, infections, and biochemical imbalances. Physicians often prioritize this level of explanation because it is concrete, measurable, and directly related to medical interventions such as medications, surgeries, and other treatments (Baszanger, 1998). On the other hand,

[94] While the first perspective of biomedicine as a scientific enterprise is grounded in positivist science, the second perspective as a symbolic-cultural expression is informed by hermeneutic and post structural interpretations.

psycho-social circumstances refer to the psychological, social, and environmental factors that can influence a person's health and well-being. This includes things like stress, lifestyle factors, social support networks, and cultural influences. Baszanger's observation was that physicians sometimes regarded these factors as less significant or dismissed them as 'nothing' compared to cellular pathology. This hierarchy reflects a historical bias in medicine where physical and biological factors were often considered more real or important than psychological and social factors (Armstrong, 1987).

In conclusion, Western biomedicine has faced significant criticism for its limited consideration of social and psychological factors in treating illness, often reducing pain and illness to purely physical phenomena (Flor & Turk, 2011). The influence and limitations of Cartesian thought in this biomedical approach will be explored in the next section.

3.2.1.2. The Limits of Mind-Body Dualism and Cartesian Thought

Contemporary Western culture is deeply rooted in principles of nature-based realism, materialism, self-governance, self-reliance, individualism, self-centeredness. These principles shape various aspects of society, including healthcare. With the emergence of the age of The Enlightenment[95] an epistemological shift happened; a way of knowing based on firsthand, sensory-based empirical data is favored (Jordonova, 1989, p. 24). In this context, one of the foundational philosophical assumptions is the belief in the separation of the mind from the body (Gordon, 1988, p. 40). Essentialist dichotomies in the context of Western thought often involve the separation of various concepts: the mind is distinguished from the body, spirit from soul, active from passive, form from matter, rational from irrational, reason from emotion, free from determined, objective from subjective, male from female, immortal from mortal, and culture from nature (Yardley, 1999; Gordon, 1988; Kirmayer, 1988). These divisions

95 The Enlightenment refers to an intellectual and philosophical movement that took place primarily in Europe during the 18th century. It emphasized the use of reason, empirical evidence, and scientific methods as the primary sources of knowledge and authority, challenging traditional ideas based on religion and superstition. The Enlightenment promoted ideals such as individual liberty, progress, tolerance, and the belief in the power of human reason to improve society and solve problems (Pinker, 2019).

reflect a longstanding philosophical tendency to categorize elements of existence, shaping how we perceive and interpret the world around us. The dualist portrayal of the mind as being distinct and detached from the physical world, "led to a conception of knowledge acquisition as the process whereby the rational, individual mind could, through systematic observation, deduce the nature of material world and thereby gain the ability to predict and control physical events (Yardley, 1999, p. 33).

This mind-body dualism[96] creates binary oppositions, highlighting a distinction between mental and physical well-being.[97] This dualism, which posits a fundamental distinction between mind and body, has had a profound and enduring influence on the field of healthcare science. This influence is evident in the frequent conceptualization of the body as a mechanical system (Keller, 2000, p.238). The philosophical assumptions underlying Western biomedicine have fostered an approach that treats disease as a distinct and separate entity within the body. This perspective, shaped by mind-body dualism and principles of materialism and individualism, views illness as an independent condition to be treated in isolation (Comaroff, 1982; Gordon, 1988).

For understanding the key points about how mind-body dualism influenced the development of medicine, the practice of human cadaveric dissection becomes a

96 The idea of mind-body dualism was popularized by the French philosopher René Descartes, who argued that the mind (or soul) is distinct from the physical body and can exist independently of it. This belief often leads to the conclusion that the mind is immaterial and immortal, while the body is material and mortal. While mind-body Dualism is a key component of Descartes' philosophy, Cartesian Thought encompasses a broader range of ideas, including skepticism, rationalism, and the belief in the existence of innate ideas. Keller (2020) narrated from Magee (1987) that, according to Descartes' philosophical theory, the human being consists of two distinct entities: the mind and the body. The mind, which he believed to be the true essence of a person, is non-physical and immaterial. In contrast, the body is merely a mechanical, lifeless vessel in which the mind resides (Magee, 1987).

97 At this point, it is necessary to point out that Rene Descartes's philosophical dualism cannot be irreducible to the mechanistic theories that ignore the effect of the mind on the body. Duncan argues two points about Descartes's Cartesian dualism in relation to contemporary biopsychosocial theory of pain:

"1. That, while Descartes describes bodily processes in mechanical terms, and defines mind and body as separate substances, the unity of the human body and mind are an integral part of his dualism. While there is considerable uncertainty about precisely how he thought this separate but-unified relationship works, Descartes should not be associated with mechanistic theories that ignore the effect of the mind on the body.

2. That contemporary biopsychosocial theory may not altogether escape mind-body dualism, even if it rejects the Cartesian version. And that Descartes has more in common with the biopsychosocial model of pain than he has been given credit for" (Duncan, 2000, p.486).

pivotal topic. Dualistic way of thinking enabled and facilitated the practice of dissecting human cadavers[98], an activity previously opposed by the church. This approach reinforced a distinction between medical and psychiatric disorders, with medical conditions deemed fit for scientific investigation, such as dissection, while psychiatric disorders were confined to asylums. Cartesian dualism, by separating mind and body, not only advanced anatomical knowledge but also hindered holistic care and contributed to the divide between psychiatric care and other medical specialties (Duncan, 2000; Ghosh, 2015).

Mind-body dualism posits that illness exists physically within the body and should be treated as a distinct entity (Mehta, 2011; Comaroff, 1982; Gordon, 1988). In modern biomedicine, the body is viewed as a machine characterized by its functionality, systemic nature, and mechanical attributes (Moreno Leguizamon, 2005). Health reflects mental well-being, while illness reveals the body's true state, disrupting rational thinking, social interactions, and self-control. Thus, conventional biomedicine, focused on rationality, is seen as most effective in managing illness to prevent disorder and chaos (Mehta, 2011; Kirmayer, 1988).

Additionally, the scientific biomedical model of illness is evaluated within the understanding of cause and effect. Consequently, biomedical practices often focus on controlling and managing the body (Lupton, 2012). In "The Birth of the Clinic: An Archaeology of Medical Perception," originally published in 1963, Foucault (1973) argues that the transformations in biomedical practices during the late 18th century were driven by a desire to assert increased control over the human body.[99] In his historical and philosophical analyses of the evolution of medical knowledge in France, Foucault identifies the founding of the medical clinic as a crucial turning point in the comprehension of the human body. The health care practitioners of the

98 For a historical elaboration on the practice of human cadaveric dissection, its revival in Medieval Europe and later becoming the primary means of learning anatomy see:
Ghosh S. K. (2015). Human cadaveric dissection: a historical account from ancient Greece to the modern era. Anatomy & cell biology, 48(3), 153–169. https://doi.org/10.5115/acb.2015.48.3.153

99 According to Foucault, medicine is one of the major institutions of power. He makes his point clearer in his book, The History of Sexuality, that medicine finds the right to categorize among bodies as abnormal or normal, hygienic or unhygienic, controlled or in need of control (Foucault, 1979, p. 54).

18th century utilized objective measurement techniques developed by scientists of the time. Influenced by the positivist view, the human body was seen as an 'object' of scientific study (1973).

3.2.1.3. Medico-Scientific Gaze

In *The Birth of the Clinic*, Foucault (1973) outlined the genesis and evolution of what he termed the *medical gaze.* "The gaze is taken as a metaphor for the sharp, analytical, and progressive power of observation, not only of medicine but also of human 'sciences' in general" (Moreno Leguizamon, 2005, p. 3304). Foucault aimed to examine the historical progression of discourses that influence contemporary medical methodologies; medico-scientific *epistemes*[100] were replacing religious ones. He perceived the human body as a significant domain for the exercise of political and ideological influence, surveillance, and governance. Foucault refers to the 'anatomical atlas' that is the body constituted by the medical gaze within the scientific model. While explaining how the body is constituted as an object of science, he underlines that the human body is perceived as devoid of subjectivity or personal experiences. This constitution occurred as medical knowledge increasingly prioritized the observable aspects of diseases such as visible components. Due to technological improvements, for example, the invention of the stethoscope has paved the way for prioritizing the visible among the "invisible" aspects of disease.

The Medico-Scientific Gaze, rooted in medical and scientific observation principles, views the human body as an object of science. Foucault (1973) highlights that medical practice evolved to include not just visual observation but also touch and hearing, improving diagnostic capabilities. This shift, however, led to a focus on 'objective' clinical measures and visible diseases, often at the expense of patients' subjective experiences of pain and illness. Lupton further explains how medical encounters exemplify this trend toward monitoring and observation:

> The doctor investigates, questions, touches the exposed flesh of the patient, while the patient acquiesces, and confesses, with little knowledge of why the

[100] In this context, episteme refers to the foundational structures and intellectual assumptions that define and limit the knowledge and scientific practices within a specific historical period (Foucault, 1974)

> procedures are carried out. In the doctor's surgery the body is rendered an object to be prodded, tested and examined. The owner is expected to give up his or her jurisdiction of the body over to the doctor. In severe cases of illness or physical disability the body is owned by the medical system, while in mental illness the body is the apparatus by which the brain is kept restrained, often against the owner's will. (Lupton, 2012, p.24)

This excerpt illustrates how the human body is viewed as an 'object of science' within the biomedical model. For physicians, the patient's body becomes an area for investigation and evaluation. A key issue with this approach is that it expects patients to surrender control of their bodies to doctors, assuming that only professionals can interpret bodily information and make treatment decisions without considering the patient's perspective. Consequently, this model not only facilitates the monitoring of patients by doctors but also undermines the concept of patient autonomy[101], as patients are encouraged to view their own bodies as objects (Foucault, 1973).

To conclude, the underlying philosophy of the biomedical perspective, which is based on the principles of medical and scientific observation, has resulted in the monitoring and observation of the human body. These concepts of 'medical gaze', 'body as object of science', and 'objectification of patients' will be operationalized in Chapter 4.1. and 4.2. with the accounts of the participants and field study notes.

3.2.1.4. The Body, Social World, Pain and Human Experience

> Understanding illness begins with an understanding of illness as it is lived (Merleau-Ponty, 1962)

Merleau-Ponty (1962) emphasizes that understanding illness requires engaging with it as a lived experience. To truly grasp the nature of illness, one must consider its embodied dimensions, including how it affects an individual's sense of self and their interaction with the world. This approach moves beyond detached, objective

[101] Autonomy - as such does not exist according to Foucauldian perspective – it is a discursive possibility that is possible only through or as a discourse. Within the philosophical framework proposed by Michel Foucault, it is not possible to conceive of an autonomous, inherent self or speech that exists independently of discourse. The concept of 'discourse versus speech' is inadequate, as all speech is inherently situated within discourse. Consequently, the notion of speaking without the influence of discourse is untenable.

observation, acknowledging that illness is not just a clinical or scientific phenomenon but a deeply personal and bodily experience.

Although in the biomedical practices, the particular experience of the patients has been undermined by practitioners, the social aspects of the body have started to be included in the analysis by the attempts from phenomenologists, anthropologists, and social constructionists. The view towards body have changed by the theoretical developments of Mauss (1973), Merleau-Ponty's *phenomenology*[102] (1962), and Bourdieu's theory of practice (1977). The body is starting to be understood as inseparable from social dynamics.[103] Analyzing the body requires acknowledging how social processes shape and influence it. This shift in perspective is evident in social science research on health, particularly within medical anthropology (e.g., Guttmacher, 1979; Morsy, 1980; Murphy, 1987; Kleinman, 1988; Stacey, 1988; Scheper-Hughes & Lock, 1991; Lindenbaum & Lock, 1993; Lock, 1993; Turner, 1996). Since Talcott Parsons introduced the concept of the Sick Role in 1951, scholars in social sciences, psychology, and critical medical humanities have explored, challenged, and expanded his views on the lived experience of illness (Burnham, 2012, 2014; Shilling, 2002; Charmaz, 1999; Kleinman, 1988).

Taking a more specific perspective, studies on pain have contributed to discussions surrounding the body, the social world, and the human experience of pain. Social constructionism and phenomenology have also paved the way for a closer focus on the pain studies questioning how perceptions of pain is socially constructed and how

102 In the 19th century, post-Kantian philosophy introduced crucial ideas linking cognition to embodiment and action. This was particularly evident in the phenomenological tradition. Maurice Merleau-Ponty, by the mid-20th century, provided a clear and explicit articulation of these notions in his work (Bolton & Gillett, 2020).

103 Expanding on Merleau-Ponty's perspective, we can consider several key dimensions of understanding illness as it is lived: Illness is a deeply personal experience that goes beyond symptoms to alter an individual's inner world. It encompasses subjective dimensions such as pain, fear, uncertainty, and hope, all of which shape how the illness is lived and understood. Illness affects the whole person, altering physical and sensory capacities, and can significantly impact one's identity, challenging self-image, control, and life purpose. It also raises existential and spiritual questions, influencing how individuals cope and find meaning. Additionally, social and cultural contexts play a crucial role, as beliefs, values, and norms shape the perception and response to illness. Understanding illness requires acknowledging these multifaceted dimensions. By adopting a phenomenological approach that focuses on the lived experience of illness, we gain a deeper understanding of its complexities and the unique challenges faced by those who live with it.

beliefs about pain are formed and influenced by interpersonal communication (see for example Kern, 1987; Kleinman, 1988, 1992; Morris, 1991; Delvecchio Good et al., 1992; Bendelow, 1993; Bendelow and Williams,1995)

3.2.1.5. Women's Body and Embodiment

In response to the mechanical conceptualization of the body as a mechanical system by the dualistic philosophy of Descartes; Merleau-Ponty acknowledged the human body as sentient, and alive (Leder, 1992; Keller, 2000). This view created a vision of the body that has implications for healthcare science (Leder, 1984).

Moreover, since the 1970s, feminist scholars have extensively examined the social and cultural dimensions of the body, focusing on *embodiment*, identity, and the interaction between biology and culture in influencing bodily experiences. Concerning the reproduction of women, the discussions delve into the complex interaction between biology and culture from a feminist viewpoint (see, for example, Boddy 1989; Rapp 1992; Bordo 1993; Garro, 1994; Grosz 1994; Martin 1987, 1991; Sullivan, 2001, 2015; Moss & Dyck, 2003; Chrisler, 2004; Shilling, 2005). Feminist studies have critically analyzed medicine's role as a tool of social control and its shaping of gender constructs within medical discussions.[104] In line with this literature, my thesis argues that bodily conditions such as physical symptoms, illness, menstrual bleeding, and pain are inherently social and cultural, challenging the biomedical model's tendency to downplay social factors. To clarify this perspective, it is essential to discuss embodiment in relation to gender from feminist viewpoints.
Feminist perspectives have extensively explored the body and medicine, examining topics like illness experiences, social control over gendered bodies, and the power dynamics between patients and doctors. However, feminist studies do not present a unified stance on women's embodiment. The debate often centers on whether the female body is primarily shaped by biological factors or by social and cultural

104 Since the 1960s, feminist analysis has been instrumental in emphasizing how embodiment is shaped by gender, particularly through the efforts of the second-wave feminist movement. This movement shed light on social constructs of sexuality and gender, making the body a central theme in feminist discussions (Caddick, 1986). See, Caddick, A. (1986) 'Feminism and the body', Arena, 74: 60–88.

influences. While some feminist scholars emphasize biological essentialism, others advocate for a more relativistic view, seeing the body as largely a social construct. To provide a clearer understanding, I will outline two key approaches within feminist discourse on female embodiment. The first prominent feminist approach advocates embracing women's physical experiences as a source of empowerment. In contrast, the second approach suggests downplaying these distinct experiences, arguing that they contribute to the exclusion and subjugation of women. As Lupton (2012) notes, feminist discourse often grapples with "a constant tension between recognition of the uniqueness of women's embodied experience and the desire to deny that any such uniqueness exists" (pp. 137-138).

On the one hand, when we consider the first discourse, which acknowledges the unique embodied experiences of women,[105] we see that they embrace such experiences as central to femininity. The ability of women to conceive and lactate, breastfeeding, and bodily changes during menstruation, pregnancy, and menopause are seen "as evidence of women's specialness and power, as experiences to be enjoyed and welcomed as essential to femininity" (Lupton, 2012, p. 138). Thus, women's distinct physical experiences are seen as embodying the core of femininity, which is valued as both intrinsic and empowering.

This view can be criticized for having a risk of falling into the trap of biological determinism.[106] However, one of the reasons social sciences have been hesitant to theorize the body is due to the fear of falling into the trap of biological determinism, which was common in natural sciences (Turner, 1996). As a result, macro-sociologists have focused primarily on the 'social system' emphasizing structural, political, and economic aspects of social control. This focus has effectively rendered the body invisible in sociological analyses. While micro-sociologists have concentrated on individual behavior as socially constructed, they have largely overlooked how embodiment, or the lived experience of having a body, influences

[105] The physiological attributes associated with the female body may include pregnancy, undergoing in vitro fertilization (IVF) treatment, childbirth, lactation, termination of pregnancy, use of hormonal contraception, undergoing female circumcision, encountering symptoms of premenstrual syndrome, menstruation, and menopause.

[106] Indeed, some feminists have celebrated this view. However, I critique biological determinism, as I believe that biology cannot be considered in isolation from social, cultural, and psychological factors.

decision-making and social interactions (Turner, 1996). This oversight is a significant limitation in sociological research, as the body is a fundamental aspect of human existence and plays a crucial role in shaping our experiences and interactions with the world around us.

Several factors contribute to the social sciences' reluctance to theorize or historically contextualize the body. One key reason is the enduring influence of Cartesian dualism, which separates the mind and body into distinct entities. This dualistic perspective has led to a tendency to privilege the mind over the body, resulting in the devaluation of the body as a legitimate object of sociological inquiry. Additionally, there is a concern about essentialism—the notion that fixed, immutable essences define individuals or groups. This concern has made some social scientists wary of developing theories about the body, fearing that such theories might reinforce essentialist views related to race, gender, or other physical traits. However, excluding the body from sociological theory has ultimately limited our understanding of social life (Sullivan, 2001; Butler, 1990; Shilling, 1993; Turner, 1996). The body is not merely a passive vessel that carries around the mind; it is an active and integral part of human experience.[107] Our bodies shape our perceptions, our interactions, and our sense of self.[108]

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107 The gender perspective has been a subject of ongoing debate and contention. At the core of these discussions lie tensions between biological and cultural factors, objectivism and relativism, and essentialism and constructivism. The traditional distinction between 'sex' and 'gender' was initially introduced to challenge prevailing views that explained differences between the sexes and social norms solely based on biological factors. This distinction, however, proved to be problematic as it created a seemingly rigid dichotomy that failed to capture the complex interplay of biology and culture in shaping gender identities. More recent theories have moved beyond this dualistic framework and propose a more nuanced understanding of gender as both biologically and socially constructed. This perspective acknowledges the influence of biological factors such as chromosomes and hormones on physical characteristics, while also emphasizing the role of social and cultural factors in shaping gender roles, behaviors, and identities (Butler, 1990).

108 Moreover, they are also sites of power and control, as evidenced by the ways in which bodies are regulated, disciplined, and punished. By theorizing and historically situating the body, social scientists can gain a deeper understanding of social processes and structures. They can also challenge essentialist notions of identity and explore the ways in which the body is both a source of constraint and a site of resistance. In their comprehensive discussion on lived experience, Johansson et al. (1999) highlight how gender order, which subordinates women to men, manifests overtly in statistics related to income, position, and power (Doyal, 1995; Sainsbury, 1996), yet also operates in subtler, variable ways. They argue that lived experience reveals how gender order is maintained, challenged, or altered in individual lives. What might be perceived as personal free choice could actually stem from constrained circumstances shaped by culture, class, or political legislation. Instead of interpreting

In this thesis, I critique biological determinism while embracing the lived experience of embodiment, arguing that biology is deeply intertwined with social, cultural, and psychological dimensions. Grosz's work rejects the reductionist nature-culture dichotomy and highlights the potential within biological existence for transformation by cultural, social, and historical forces (Grosz, 2008 [1999]).

There is an interplay between various aspects of human experience. For instance, women's bodies and health cannot be fully understood solely through biological lenses; likewise, social construction is not sufficient without the acknowledgement of a more nuanced understanding of women's embodiment experiences. "Women are somehow more biological, more corporeal, and more natural than men" (Grosz, 1994, p.14). Her perspective, which aligns with feminist materialist theories, emphasizes that understanding women's bodies and health requires recognizing the materiality of the body alongside social constructions. She argues that gender and sexuality are not purely social constructs but are also shaped by the materiality of the body, a view central to this research. The key arguments in Grosz's work which are instrumental for this research are:

(1) The materiality of the body: Grosz argues that the body is not a passive object, but rather an active and dynamic site of meaning production. She emphasizes the importance of the body's materiality in understanding gender and sexuality.

(2) The role of social and cultural factors: Grosz acknowledges that social and cultural factors play a significant role in shaping our understanding of gender and sexuality. However, she argues that these factors cannot be understood in isolation from the materiality of the body.

However, Grosz's endorsement of a biology which supports materiality of the body has been criticized by Fausto-Sterling (2000) and Fine (2012) because of its possible reinforcement of the essentialist notions of gender. They argue that Grosz's work fails to adequately account for the fluidity and diversity of gender and sexuality, and that it perpetuates binary categories that can be oppressive and exclusionary. Having

empirical sex/gender differences as inherent biological or psychological traits (e.g., women's lower pain thresholds), a gender perspective questions why such differences arise (West, 1993).

said this, it is necessary to note that Grosz's ideas have sparked a lively debate within feminist theory and her work has been influential in shaping contemporary understandings of gender and sexuality (Jagger, 2015). In my thesis, I diverge from the positions of Fausto-Sterling (2000) and Fine (2012). To address the limitations of their critiques, I present a counterargument based on feminist phenomenologist Sullivan (2015). Sullivan argues for a nuanced view of sex/gender, asserting that it does not necessarily reinforce a binary gender system or a fixed body concept (2015, p. 27). Instead, she emphasizes that the biological reality of sex/gender is shaped by the intersection of sexist oppression and heterosexism, challenging the notion that biology alone determines gender (Lennon & Fischer, 2024).

Sullivan, in her book, *The Physiology of Sexist and Racist Oppression,* clearly posits that:

> Jettisoning biology-culture dualisms instead must involve critically rethinking the physiological dimensions of sex/gender. Doing so is crucial to the psychosomatic health of women of all races. Just as the biology-culture trap leaves significant racial health disparities in place, it also does little to relieve the psychosomatic suffering of women who, for example, disproportionately suffer from various pelvic floor dysfunctions, gastrointestinal illnesses, and autoimmune problems. Sex/gender is biological, not in a pre-critical sense of an unchanging bodily given but in the critical, dynamic way that sexed/gendered differences can become biological through the embodiment of the effects of sexist (and often abusive) practices. This view of sex/gender as biological does not operate through the prioritization of reproduction, as the category of sex often is used or assumed. (2015, p.27)

I align with Sullivan's perspective, which critiques the dualism between biology and culture. She argues that overcoming this dualism is essential for comprehending women's psychosomatic health, as conditions like pelvic floor dysfunction and autoimmune disorders are deeply intertwined with bodily experiences. Sullivan suggests that understanding sex and gender as dynamic concepts—shaped by sexist practices rather than fixed biological givens—can address significant gendered health disparities. She also critiques the misleading nature of separating social and biological factors and advocates for using Nancy Krieger's concept of 'embodiment' to better understand its impact on health and other aspects of life:

> Not only does so-called social construction not mean that what is constructed is unreal, but it also does not mean that what is constructed is non-biological. My hunch is that the language of "social construction" too easily lends itself to this trap, and thus it should be avoided. Far superior is social epidemiologist Nancy Krieger's development of "embodiment" as an ecosocial concept designating active organisms that physiologically incorporate their world through activity. As I understand it, Krieger's notion of embodiment is very similar to the concept of transaction. If the language of social construction is retained, however—as it generally seems to be in the empirical sciences—then we must be willing to speak of biology as socially constructed. Not merely the discipline, but biological and physiological matter itself: cortisol levels, allostatic loads, nerve growth factors, muscle fibers, bone tissue, epigenetic markers, and so on. The inequalities of the social world are no different than, for example, the food we eat and the air we breath: they "become literally embodied into physio-anatomic characteristics that influence health" and other salient aspects of human existence. (Sullivan, 2015, p.23)

Her argument urges a reevaluation of the relationship between biology and society, advocating for a framework that integrates social environments with biological processes. This perspective offers a more nuanced understanding of health and human behavior, moving beyond simplistic binaries to embrace the complexity of lived experiences. For Sullivan, social inequalities, akin to factors like diet and air quality, are physically embodied.

According to the analysis of Lennon and Fischer (2024), the 'return' to biology, there is two overarching interrelated philosophical frames as *pragmatism*[109] and the *new materialism*[110]. New materialism responds to the linguistic turn that has dominated the humanities in recent decades, which is said to have overlooked the materiality of matter. This view positions matter as an active and dynamic entity, endowed with inherent tendencies, departing from traditional Aristotelian and Newtonian views

[109] Seigfried (1996) focuses on the intersection of pragmatism and feminism. Seigfried contends that pragmatic point of view centers experience as a basis for analysis rather than language. Through the lens of this philosophical framework, it is possible to reconsider the connection between "the material" and "the discursive (and the role of the gendered body therein)" (Lennon & Fischer, (2024). This notion is elaborated by Fischer (2018) with the argument that the emphasis on biology which is characteristic of new materialism (see for example, Davis, 2009; Barad, 2007; Kirby, 2002,2008) is complemented by pragmatist philosophy, particularly the work of John Dewey. According to Fischer, the pragmatist approach allows for an understanding of the gendered body that transcends traditional dualistic conceptions.

110 The new materialism presents a groundbreaking shift in the understanding of materiality, as articulated by Manuel DeLanda (2015) and his contemporaries.

(DeLanda, 2015). Drawing upon insights from both the humanities and natural sciences, this approach suggests a post-human ontology that acknowledges the inherent vitality and potential within matter (Crellin, 2018). Key figures in this field include Karen Barad (2003, 2007), Jane Bennett (2010), Rosi Braidotti (2011), and Manuel DeLanda (2015), who have applied new materialist thinking across various disciplines (Dolphijn & Tuin, 2012). This emerging thought has been influential in the fields such as philosophy, cultural theory, feminism, science studies, and the arts, offering new perspectives on the nature and significance of materiality in our world.

According to Van der Tuin (2009) new materialism is an epistemological and methodological trend which has entered the academic arena not as a contestation, but as one of the theoretical frames of third wave feminism. The new materialism, also called a 'materialist turn' in feminist theory (see Carastathis, 2009) preoccupied with addressing this oversight of the materiality, has evolved partly through debates with post structuralism and Judith Butler's theory of the body. Critics of Butler's theory argue that it does not grant sufficient significance to the physical body's materiality in the process of its materialization.

> The new material feminisms attempt to address such an imbalance by returning to the materiality of matter. Their aim is to find a way of theorizing the interimplication of the discursive and the material, the natural and the cultural, the body and its social construction in a way that is more respectful of the agency of matter. (Jagger, 2015, p. 321)

Similarly, in her review of Karen Barad (2007)'s book, *Meeting the Universe Halfway*, Benavente (2010) articulates the emergence of the book into the academic domain during the period of transition from second- to third-wave epistemologies. It presents an *agential realist ontology* that has the potential to assist feminist studies in illuminating the interwoven nature or complexity of material existence.

> Agential realism, the term Karen Barad uses for her new ontology, provides sensitive descriptions of material-discursive practices that promote differences that matter. This ontology rejects the foundational separation between the object of observation and the observer because this division assumes the object as passive and the observer as active. Barad's ontology describes the world through apparatuses in which both object and observer, human and non-human, are connected (Benavente, 2010, p. 84).

Barad's ontology rejects the foundational separation between the object of observation and the observer, human and non-human. Similarly, Sullivan (2015)'s objective is to direct attention to the notions that often oversimplify or distort the complex dynamics of human relationships, potentially overlooking the ways in which individuals shape and are shaped by their social interactions. By avoiding these fragmented perspectives, she aims to present a more comprehensive understanding of human interconnectedness. In order to elaborate on Sullivan's suggestion, Dolezal (2015) indicates that:

> Human transactional corporeality includes the physical, the mental, the social, and the cultural dimensions of human life; it is open, permeable, and in constant shift. Thus, bodies are neither matter sealed off from culture or matter imprinted with the meaning of the surrounding culture. Bodies transact, they are activities co-constituted and co-existing in an open-ended and permeable dynamic relationship with context. Thus, there are no bodies and no corporeality in itself. What is essential in our context is her insistence on the co-constitutiveness and mutual influence of bodies in context – in all dimension. (2015, p.150)

Dolezal (2015), emphasizes that bodies are not isolated from culture or merely shaped by it but are dynamic entities influenced by various factors. Both Barad and Sullivan, therefore, emphasize the importance of recognizing the intricate entanglements and co-constitutive relationships that define our existence, challenging reductive views and advocating for a more integrated approach to understanding the interplay between entities and their environments.

To conclude, feminist theorists of embodiment have significantly influenced the field of embodiment philosophy through their contributions to philosophical discourse. Together with critical race theorists and theorists of (dis)ability, these feminist thinkers have underscored the importance of the body in ethical, social, and political contemplation. Feminist literature emphasizes the need for a wide array of philosophical theories to comprehend the nature of the embodied self. Therefore, the literature around the works of Sullivan (2015), Barad (2007), Bordo (1993), Bobel (2010) and Grosz (1994) offers lines for discussion and conceptual frameworks to explain the bodily experience of women for my fieldwork data.

The second feminist discourse, rooted in constructivism, challenges the notion of distinct women's bodily experiences, arguing that historical patriarchal definitions have used these experiences to justify women's subjugation and exclusion from public and economic spheres. This perspective views women's embodiment "as purely social constructions constituted by medical and scientific discourses" (Lupton, 2012, p.138). Thus, their urge is to explore the ways to minimize the differences between the sexes[111] to underline the equality of men and women or to reduce the inequalities in public space.

This relativist perspective highlights the significance of cultural practices and discourses in shaping distinctively sexed and gendered bodies (Haraway, 1988), refuting the concept that nature and the physical form exist independently of societal influence.[112] Since this viewpoint adheres to the constructivist philosophy, where physical bodies are considered as symbolic representations, it also argues that bodies can be managed through deliberate decision-making processes.

As Susan Hekman (2008) contends, discourse has come at the expense of the material, resulting in a decline in focus on objective reality. This shift has significantly impacted our understanding of the world around us. While the intent has been to comprehend reality through discursive mechanisms, the unintended consequence has been an elevation of the discursive element itself, leading to a distorted and subjective view of the world. Namely, the increasing emphasis on discourse has led to a devaluation of the material, relegating it to a secondary status. This has resulted in a diminished appreciation for the objective reality.[113]

111 For instance, Simone de Beauvoir. The Second Sex.

112 Donna Haraway (1988), argues that the notion of the 'cyborg' performs this function, expressing an ideal of a 'humanoid hybrid', a combination of humanity and technology in which categories of sexuality, ethnicity, gender and indeed the distinction between humanity and technology are indeterminate and fluid.

113 The elevation of the discursive element has resulted in a proliferation of subjective interpretations and narratives. While discourse can shed light on different perspectives and experiences, it is essential to recognize its limitations. Discursive constructs are inherently influenced by individual biases, values, and beliefs, making them susceptible to distortion and manipulation. As a result, the line between objective reality and subjective interpretation becomes blurred, leading to a relativistic view of truth and knowledge (Jagger, 2015).

In conclusion, the last part of this chapter, I have discussed firstly the feminist views which are embracing unique embodiment of women; and secondly, I have discussed the relativist perspective to women's embodiment as purely social constructions. On the one hand there is a risk of biological determinism which underestimates the social factors and on the other side of the coin there is supreme relativist constructionism and overemphasis on discourse which undermine the "agency of matter" and physical realities of women. In accordance with this literature, in this thesis, I suggest that bodily conditions (e.g. physical symptoms, illness, disease, pain) are simultaneously social and cultural conditions, as opposed to the biomedical model's underestimation of the social conditions and subjectivity of a person in the diagnosis and the treatment process. The body is not only an object of culture but also a social one. The body is not only a biological mechanism, but also a social one.

3.2.2. Holistic Approach to Health and Illness

> We cannot remind ourselves too often that the word healing derives from an ancient origin, meaning 'whole'—hence our equation of wholesome and healthy. To heal is to become whole.
>
> (Gabor Mate,2019, p.268)

In the excerpt above, Mate emphasizes that the concept of healing is fundamentally about becoming whole. The word "healing" originates from an ancient term meaning 'whole,' suggesting that to heal is to restore wholeness. Over 3000 years ago in ancient Greece, the concept of 'Holos' emerged, asserting that diseases affect the entire person, not just the afflicted part. Healing, therefore, involves not only physical recovery but also the restoration of unity and balance within oneself (Drossman, 1998, p.260). This holistic view, which perceives the individual as an integrated whole rather than a collection of parts, remains central in many non-Western medical systems. For instance, traditional Chinese medicine views qi (life force energy) as crucial to health, with imbalances leading to illness. Similarly, Ayurvedic medicine from India focuses on balancing the three doshas—vata, pitta, and kapha—to maintain health. These practices combine therapies such as herbal remedies, dietary changes, meditation, and yoga to promote overall well-being.

In the modern era, there is a growing recognition of the limitations of the reductionist approach to medicine and a renewed interest in holistic practices. While Western medicine has made significant advancements in treating specific diseases and conditions, it has often neglected the importance of addressing the whole person. Healing has been compartmentalized into a narrow medical framework, focusing primarily on physical symptoms. Though medical interventions can be life-saving, they are not the only means of achieving health.

Since the mid-nineteenth century, many researchers and physicians in the West have recognized that disease is rarely caused by a single factor. The body, psyche, and environment interact in both the onset of illness and the restoration of health. This has led to a growing shift toward holistic healthcare, which acknowledges the interconnectedness of physical, psychological, and social factors in overall well-being. As discussed for example by Berg and Sarvimäki (2003) and Gendlin (1973), the philosophical orientation of a holistic perspective is deeply rooted in the works of foundational thinkers such as Sartre (1956), Heidegger (1989), May (1983), Frankl (1963), Merleau-Ponty (1962), Dilthey (1961), and Husserl (1950). A holistic-existential perspective in health emphasizes the uniqueness and subjectivity of each individual's existence and their relationship with the world. The lived experience becomes important. This approach acknowledges that the human experience is subjective and multifaceted, encompassing not only the physical aspects of life but also the psychological, emotional, and spiritual dimensions. Central to this philosophical framework is Heidegger's concept of "being-in-the-world" (1989), which emphasizes the interconnectedness of individuals with their environment. This perspective asserts that our existence is deeply embedded in the world around us, with our experiences, perceptions, and actions shaped by and shaping our surroundings. Within this context, a purely biomedical approach is deemed insufficient for understanding illness, as it focuses primarily on observable disease processes. In contrast, the existential model emphasizes individual experiences and the personal meaning of illness, recognizing that suffering is not just a biological phenomenon but a deeply personal one (Berg & Sarvimäki, 2003). The holistic approach builds on this by addressing all dimensions of a person's existence—physical, emotional, mental, and spiritual—viewing them as interconnected.

Imbalances in one area can affect overall health, making it essential to foster harmony across all domains for optimal well-being (Guttmacher, 1979).

At the core of the holistic approach lies the belief that the individual is an intrinsic part of a larger interconnected web of life.[114] This perspective emphasize the significance of cultivating relationships with oneself, others, and the natural world. Holistic practitioners frequently draw upon ancient healing traditions, such as Traditional Chinese Medicine, Ayurveda, which have been employed for centuries. This approach encourages self-awareness, self-care, and the cultivation of a healthy lifestyle that supports the well-being of the person (Guttmacher, 1979). In the next part of the chapter, I will present the BPS theoretical approach as a conceptual tool for the analysis of women's reproductive health.

3.2.2.1. The Biopsychosocial Model of Health and Illness: George Engel's BPS Systems Theory

"There is no illness of the body apart from the mind"
Socrates

The ancient Greek philosopher Socrates highlights the mind-body connection, suggesting that physical health is influenced by mental and emotional states. His quote addresses that the mind can significantly impact bodily healing. This concept is often referenced in discussions of the BPS model, emphasizing the interplay between biological, psychological, and social factors in health and well-being. The BPS model, which considers the interplay of biological, psychological, and sociological factors in shaping illness and disease, was first scientifically introduced in 1977 by medical doctor (MD) and psychiatrist George Libman Engel[115]. During the 1980s

[114] In the analysis of health and medicine within social theory, the political-economic perspective and some more specific theoretical approaches such as the Fundamental Cause Theory focuses on the impact of social politics, and socioeconomic on individual health outcomes and structural analysis of healthcare systems. The Fundamental Cause Theory posits that societal factors, such as poverty, ethnicity, race, and discrimination, are the fundamental causes of poor health. More recently, an individualistic approach to health has emerged, which focuses on the role of lifestyle and behavioral factors in health outcomes.

115 George Libman Engel (December 10, 1913 – November 26, 1999) was born in New York City. He was a MD, internist and psychiatrist. Engel's life history sheds light on the significant impact of

and early 1990s, the BPS approach to medicine gained prominence. The goal was to identify etiological and preventive factors that could contribute to a better understanding and management of various illnesses (Bolton & Gillett, 2020). Engel advocated for a holistic approach to health, arguing that effective treatment requires viewing the patient as a whole rather than focusing on isolated issues. He introduced the BPS model as a scientific alternative to the reductionist biomedical model, which he criticized for its mind-body dualism and neglect of the whole person (Engel, 1981; George, 1977).

The BPS approach emerged in the late 1970s, influenced by the prevailing medical practices and professional environment of the time. Engel's groundbreaking text, "The Need for a New Medical Model: A Challenge for Biomedicine" (1977), published in the highly reputable journal *Science* argued that understanding a person's medical condition requires more than just a biological perspective. This model recognizes that the human body cannot be divided into separate categories for treatment, as physical and mental well-being are deeply interconnected. By considering the complex interactions among biological, psychological, and sociological factors, healthcare professionals can offer more comprehensive and effective care (Trachsel et al., 2023; Lugg, 2022, Neghme, 1985; Suchman, 2005). It emphasized the importance of considering the interaction between physiological, psychological, and social factors in shaping health and illness (Engel, 1977). Guillemin et al. (2015) further supports this view:

> The biopsychosocial approach is an attempt to redress the traditional model of biomedicine, with its predominant focus on pathophysiology and biological approaches to disease, and its lack of a comprehensive inclusion of the social and psychological aspects of health and illness. (p.236)

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his family in his scientific work. As Dowling (2005) narrates "his biopsychosocial profile", Engel's uncle, Emanuel Libman was a distinguished biomedical physician, and Engel's identical twin brother, Frank Engel was also a physician, who played significant roles in his development of studies (p.2039). Moreover, Engel's profile mirrored the physiological focus of his early training and research. This was influenced by Soma Weiss, Ralph Gerard, and, in Leningrad, Alexander Gurwitsch (Dowling, 2005). By the early 1950s, Engel had already achieved recognition in the fields of neurology and medicine for his research on fainting, delirium, and ulcerative colitis. Furthermore, he was embarking on studies that would establish a connection between the experience of loss and the onset of various diseases (Dowling, 2005, p.2039).

Understanding the BPS model's history is essential for appreciating its contemporary utility. The model's theoretical roots can be traced back to the mid-20th century when a group of physicians, including Engel, began to challenge the prevailing biomedical model's reductionist approach. Biomedical model operates on the assumptions[116] to discover pathology rather than understanding illness (Wade and Halligan, 2017). They argued that psychological and social factors play an equally important role in understanding and treating disorders. The BPS model occupies a prominent position as a theoretical framework within the modern psychiatric training and practice landscape (Lugg, 2022). His model offers a comprehensive perspective on health outcomes that contrasts with the traditional biomedical approach. As Guillemin et al. (2015) highlight, the biomedical model focuses mainly on biological factors, while Engel's model emphasizes the need to include psycho-social elements. This model recognizes the significant impact of psychological and sociocultural factors on health, alongside physiological aspects.

This broader view is also evident in pain studies. The biomedical model often correlates pain intensity directly with injury severity, whereas the BPS model suggests that illness results from the "dynamic and reciprocal interaction between biological, psychological, and sociocultural variables" (Flor & Turk, 2011). It stresses the importance of understanding the patient's response to pain, which is influenced by multiple factors[117] beyond the biological. Drosmann (1998) adds that illness and disease do not always align, underscoring the need to appreciate different health and illness approaches.

> To understand why illness and disease do not always correlate, we should recognize that the biomedical model is traditional and dominant within Western medical education and research. This model has two assumptions: a) Reductionism—that all conditions can be linearly reduced to a single etiology; and b) Dualism - where illness and disease are dichotomized either

116 The main assumptions of the biomedical approach are listed as 1) there is one cause for illness; 2) cause is due to pathology; 3) by removing the disease the health will return.

117 The root of pain can originate from both physical and psychosocial causes, but its persistent nature often involves a complex interplay of various factors. These factors, including life circumstances, societal expectations, and gender-specific roles. These factors have frequently been neglected or obscured in biomedical research, leading to a limited understanding of chronic pain (Johansson et al., 1999, p.1800).

> to an "organic" disorder having an objectively defined etiology, or a "functional" disorder, with no specific etiology or pathophysiology. (Drossman, 1998, p.259)

The BPS model seeks to address this reductionist view by providing a more holistic understanding. Therefore, this model stands as a cornerstone of person-centered care. It gains scientific validity through an evidence-based, patient-centered approach (Smith, 2021, 2013; Mate, 2019). This approach ensures that healthcare interventions are grounded in scientifically validated knowledge while also taking into account each individual's unique experiences, preferences, and circumstances. This dual emphasis on empirical evidence and personalized care allows the BPS model to address the limitations of traditional biomedical approaches, which often neglect the psychological and social dimensions of health.

A holistic understanding of the person is essential in the BPS model, which emphasizes the need to consider individuals as whole beings, particularly in relation to their agency, values, and personal goals (Bolton & Gillett, 2020). Engel originally highlighted the model's focus on the centrality of the person (Engel, 1977, 1980). The BPS model shares commonalities with the patient-centered care approach, and several studies have explored the relationship between these two models (Bolton & Gillett, 2020; Brody, 1999; Creed, 2005; Smith et al., 2013; Evers et al., 2014).

What distinguishes the BPS model is its ability to integrate knowledge from various disciplines, offering a comprehensive understanding of the complex aspects of individuals and their experiences. This interdisciplinary approach has been pivotal in applying systems theory[118] to health and healthcare services, leading to significant theoretical and practical advancements (Card, 2023, 2017). For example, the BPS model has been instrumental in legitimizing research on the psychosocial determinants of health, such as the impact of adverse childhood experiences (ACEs) on health outcomes. This research has broadened our understanding of how

[118] In his book, Dr. Gabor Mate also refers to the systems theoretical model as acknowledging that various processes and factors contribute to both disease and health. His book illustrates a biopsychosocial approach to medicine, which views individual biology as a result of ongoing interactions with the environment, where psychological and social factors are equally important as physical ones. Healing, as Dr. Gelmon suggests, involves achieving balance and harmony (Mate, 2019, p.268).

psychosocial factors influence health outcomes (Card, 2023; see for example, Hughes et al., 2017; Burke et al., 2011; Felitti, 2009; Schilling et al., 2007). In conclusion, the BPS model offers a holistic shift from the conventional biomedical perspective, providing a more accurate view of the complex factors influencing health and illness.

The BPS model, like any other theoretical framework, faces its share of critiques and limitations. Addressing these criticisms is essential for its continued refinement and application. Card (2023) identifies several common criticisms of the BPS model. First, it is often argued that the BPS model is not a genuine scientific model (Bolton & Gillett, 2020; Freudenreich et al., 2010; Ghaemi, 2009; Herman, 2005; Kontos, 2011; McLaren, 1998; Sadler & Hulgus, 1990; Schwartz & Wiggins, 1985). Second, critics claim that the model is too vague to be subjected to empirical testing (Álvarez et al., 2012; Epstein & Borrell-Carrió, 2005; Creed, 2005; Farre & Rapley, 2017; McLaren, 1998). Third, the model is seen as challenging to implement effectively in clinical practice, with no clear method for operationalizing it for individual patients (Ghaemi, 2009; McLaren, 1998; Creed, 2005; Herman, 2005; Sadler & Hulgus, 1990; Foss & Rothenberg, 1988; Engel, 1987). Lastly, its conceptual approach lacks practical utility (Sturmberg & Martin, 2004; Álvarez et al., 2012).

Smith et al. (2013) address these critiques in their article, suc as “Many aver correctly that the present model cannot be defined in a consistent way for the individual patient, making it untestable and non-scientific”(Smith et al., 2013, p. 265), where they suggest that the criticisms of the BPS model being unscientific stem from the lack of a consistent and systematic data. They further assert that the perceived “non-scientific” status of the BPS model is not inherent but rather a result of inadequate testable research, largely because mainstream medicine has not devoted sufficient research to the model. In 2021, Smith concluded that the patient-centered interviewing (PCI) method was necessary to make the BPS model empirical, repeatable, and testable—thereby scientific. This suggests that the BPS model can indeed be scientific, provided it is applied using rigorous, standardized methods.

3.2.2.1.1. Recognition of BPS and Acceptability Increase in World Wide

International Classification of Functioning, Disability, and Health (ICF)[119] published by the WHO in 2002, has a strong connection to the BPS model. The ICF's classification of health and health-related domains forms the basis for two measures of case complexity: the INTERMED[120] and the Oxford Case Complexity Assessment Measure (OCCAM)[121]" (Wade & Halligan, 2017).

Wade and Halligan (2017) emphasize the significance of the ICF, noting, this connection shows the practical application of the BPS model in health assessment by categorizing health-related domains through the ICF. The term 'biopsychosocial' has gained increasing prominence in scientific literature, reflecting its growing importance in health research. For instance, a search of the PubMed database shows that the term appeared in 113 articles in 1990, rising to 274 in 2010 and 896 in 2020 (Card, 2023, p. 391).

The launch of the journal *BioPsychoSocial Medicine* in January 2007 further signifies the expansion of BPS medicine. This peer-reviewed online journal explores the interconnections between biological, psychological, social, and behavioral factors in health and disease, covering fields such as behavioral sciences, neuroscience, immunology, and psycho-oncology. A study by Nakao et al. (2020) on research trends in BPS medicine found that, as of October 2020, the journal had published a significant number of articles across various categories, including original research, reviews, and case reports. These articles primarily focused on biological/psychosomatic medicine (42.9%), followed by psychology (36.3%) and public health (15.4%). The BPS framework serves as a comprehensive approach to

[119] World Health Organization. (2001, May 22). International Classification of functioning, Disability and Health (ICF). World Health Organization.

[120] Van Eck van der Sluijs, J. F., de Vroege, L., van Manen, A. S., Rijnders, C. A. T., & van der Feltz-Cornelis, C. M. (2017). Complexity assessed by the intermed in patients with somatic symptom disorder visiting a specialized outpatient mental health care setting: A cross-sectional study. Psychosomatics, 58(4), 427–436. https://doi.org/10.1016/j.psym.2017.02.008

[121] For details about OCCAM see Troigros, O., Bejot, Y., Rodriguez, P. M., & others. (2014). Measuring complexity in neurological rehabilitation: The Oxford Case Complexity Assessment Measure (OCCAM). Clinical Rehabilitation, 28(5), 499–507. https://doi.org/10.1177/0269215513512143

understanding complex health conditions, promoting the integration of biological interventions, psychological therapies, and social support systems (Card, 2023; Smith et al., 2013).

Despite the BPS model's influence within the broader medical healthcare system, its adoption in education and clinical practice remains limited (Smith et al., 2013). This is partly due to the insufficient research focus on the BPS model within mainstream medicine. However, the model has demonstrated impact in specific areas such as pain and chronic pain management (Mescouto et al., 2020; Miaskowski et al., 2020; Moseley & Butler, 2015), rehabilitation (Talo & Rytökoski, 2016; Wade, 2015; Wainwright & Low, 2020; WHO, 2002), and most notably, the psychiatric field, which has emerged as the most influential domain (Lugg, 2022; Alvarez, 2012). Especially it has been applied in disability research and functional disorders (Wade & Halligan, 2017).

Table 5. Examples of Research Topics Published in BioPsychoSocial Medicine from January 2007 to October 2020. Taken from Nakao et al. (2020).

Research area	**Research topics**
Biological	Physiological mechanisms of psychosomatic illnesses: chronic fatigue syndrome, dizziness and tinnitus, eating disorders, irritable bowel syndrome, migraine, oral health, premenstrual symptoms, tension-type headache Psychosomatic treatments: Kampo medicine, psychosomatic basic care, Yoga, Physiological markers: auditory evoked potential, ecological momentary assessment, heart rate variability, neuroimaging, salivary amylase, very long chain fatty acids
Psychological	Psychopathological concepts: alexithymia, alexisomia, somatosensory amplification, somatosensory catastrophic thought Psychological treatments: behavioral activation therapy, cognitive behavioral therapy, mindfulness

Table 5. (continued)

Social	Social science and medicine: adaptation, child abuse, education and training in behavioral/psychosomatic medicine, social support, health literacy and health communication, suicide problem, Occupational health: effort–reward imbalance at work, work engagement, work stress

Although studies have been conducted across various fields, women's reproductive health has been inadequately addressed.According to Nakao et al. (2020) in their research on trends in BPS medicine, which provides an overview of research topics published in the journal *BioPsychoSocial Medicine* from January 2007 to October 2020, there is a noticeable gap in studies specifically addressing women's reproductive health issues. As detailed in Table 5[122] , the biological research areas cover topics such as chronic fatigue syndrome, eating disorders, and irritable bowel syndrome but do not delve deeply into reproductive health. Similarly, the psychological and social research areas address broad subjects like *alexithymia*[123], cognitive behavioral therapy, child abuse, and work stress, yet they do not focus on the unique aspects of women's reproductive health.

Similarly, the top 20 articles published in *BioPsychoSocial Medicine*, ranked by the number of citations as recorded by Web of Science in October 2020 by Nakao et al. (2020). In this list, the articles[124] are including psychiatric conditions, cardiovascular implications of depression, stress reactivity, alexithymia, posttraumatic growth, and work-related stress. However, within this top-cited selection, there is a notable

[122] The table is also available in: https://bpsmedicine.biomedcentral.com/articles/10.1186/s13030-020-00204-9/tables/1

[123] Alexithymia, also known as emotional blindness, is a neuropsychological condition characterized by pronounced difficulty in identifying, articulating, originating, and elucidating one's emotions. See Wikimedia Foundation. (2024, June 14). Alexithymia. Wikipedia. https://en.wikipedia.org/wiki/Alexithymia

[124] You can see the list in the APPENDIX 5 of the Top 20 articles published in BioPsychoSocial Medicine, based on the number of journal citations, Web of Science, in October, 2020.

scarcity of studies specifically focused on women's reproductive health issues. The only relevant article is by Ogawa et al. (2011), which evaluates factors associated with anxiety and depression in female infertility patients. This article is the only representative addressing a women's reproductive health topic, indicating that within this dataset, women's reproductive health is underrepresented compared to other areas. In contrast, many of the top-cited articles focus on broader psychosomatic and psychiatric topics, such as the emphathic brain, heart rate variability in depression, the ventro-medial prefrontal cortex's role in emotion regulation, and health literacy.

Table 6. The Biomedical Model and the Biopsychosocial Model differ in several key aspects. This table is created by me with reference to the sources mentioned in parentheses.

Aspects / Models	The Biomedical Model	The BPS Model
Approach in understanding health and illness	focuses primarily on biological factors and medical interventions (Foucault, 1973)	takes a holistic approach, considering biological, psychological, and sociocultural factors (Engel, 1977; Drossman, 1998)
Assumptions	a) Reductionism b) Dualism (Armstrong, 1987; Wade and Halligan, 2017)	a) a shift: a break from the constraints of biomedical reductionism (WHO ICF, 2001)
Understanding the Body	focus on controlling and managing the body (Lupton, 2012) the body is like a machine (Keller, 2020; Moreno Leguizamon, 2005)	the human body as intelligent, sentient, alive (Merleau-Ponty, 1962) body is like alive (Leder, 1984; Keller, 2000).

Table 6. (continued)

Perspective	assumes disease is caused by any deviation from the norm of measurable physiological processes and is supported by biological findings (Foucault, 1973)	views illness as a dynamic and reciprocal interaction between biologic, psychological, and sociocultural variables (Engel, 1977)
Scope	more limited, focusing on biological aspects and medical interventions (Baszanger, 1998)	more inclusive, considering a wider range of factors that may contribute to health and illness (Mate, 2019)
Interventions	often requires patients to submit to "clinical expertise" for treatment	emphasizes patient involvement and collaboration in treatment (Smith et al., 2013)
Criticisms	criticized for being reductionist, 'medico-centrism' and not fully accounting for some illnesses (Armstrong, 1987)	criticized for being unscientific, eclectic (Álvarez et al., 2012; Epstein & Borrell-Carrió, 2005; Farre & Rapley, 2017)
while attending to the human being and disease	Grounded in the principles of scientific rigor, it is anchored in evidence-based practices (Mechanic, 2002; Starr, 1982) "Osler (modernising Hippocrates) argued that the physician's role was to treat disease in the body (biomedical reductionism) (Ghaemi, 2009)	'There is no disease, there are patients!' 'The physician treats, but nature heals' (Hipocratus, nd.) https://www.holisticmedicine.com.tr/holistik-tip/

3.2.2.1.2. BPS Model within Turkish Context: Applications and Gaps

For Turkish context, recent studies indicate a growing interest in the BPS model in medical and social research. Koloğlu et al. (2009) and Şen (2013) focus on the clinical applications of the BPS model, with emphasis on its use in diagnosing depression and in family medicine. Uncu and Akman (2004) and Akman and Ünalan (2010) explore the model's theoretical foundations and provide educational resources for primary care physicians. Cantekin and Esen (2023) apply the BPS model to child protection systems in England, suggesting broader implications for child welfare. Additionally, the book "Biyopsikososyal Boyutlarıyla Çocuk" offers an extensive examination of child development and rights, discussing various childhood issues and necessary interventions.

Meanwhile, Aktürk and Görgün (2012) and Demir (2020) delve into the distinctions and intersections between patient-centered, individual-focused, and family-oriented care within the BPS framework. Sezer Korucu et al. (2021) provide a developmental perspective on the BPS model, while Fidancıoğlu et al. (2021) focus on its application in oncological rehabilitation during the pandemic, emphasizing the integration of various therapies through tele-rehabilitation. Erdem et al. (2023) conduct a quantitative analysis of family medicine departments and academicians in Turkey, shedding light on the current state and developments in this field. Yıldız (2019) explores the integration of biomedical and BPS approaches in medical education, offering insights into the educational practices shaping future healthcare professionals. Saygılı and Ungan (n.d.) discuss holistic approaches in healthcare and the importance of comprehensive care models. Nazlıgül and Bozo (2017) examine fibromyalgia and depression through the lens of the BPS model, providing perspectives on the interplay between physical and mental health. Akdeniz and Kaştan (2023) investigate the perceived benefits of long-term yoga practice among adults, contributing to the understanding of alternative therapies within the BPS framework. Lastly, Öztekin and Öztekin (2020) study the association between depression, loneliness, and internet addiction in patients with acne vulgaris, highlighting the interconnectedness of psychological and dermatological conditions.

Together, these studies illustrate the diverse applications of the BPS model in Turkish healthcare.

The above literature highlights key BPS topics in Türkiye, such as the psychosocial aspects of diabetes management, family dynamics in mental health treatment, and cultural support in disability rehabilitation. However, there is a notable lack of research on women's reproductive health within the BPS framework, revealing a significant gap in the literature.

3.3. The Evolution and Implementation of Family Medicine in Türkiye: Theoretical Foundations and Practical Challenges

In this section, I will highlight the evolution of the Family Medicine (FM) model in Türkiye, since its principles .Over the past two decades, European primary care systems have undergone extensive reforms, including decentralization, deregulation, purchaser-provider splits, market-like contracts, performance-based payments, and a focus on consumer choice. Nordic and former socialist countries have experienced significant changes, such as person-list systems and separation of primary care and public health (Öcek et al., 2014; See, e.g., Magnusse, 2009; McDonald, 2009; Saltman, 2002).

Despite dating back to the early 1990s, the substantial phase of implementing health reforms in Türkiye began in 2003 through the Health Transformation Program (HTP) (Öcek et al., 2014). HTP was dictated and monitored by the WB (Bank, 2013; World Bank, 2003). From 2005 on, reforms in healthcare policies were implemented in the provision and financing of healthcare services, with a focus on primary care services. Family Medicine (FM) model was introduced as a pilot program, then extended to the entire country at the end of 2011. This model was based on a performance-based contracting framework (Tatar et al., 2011). The FM system, a key element of primary health care, has been implemented in most developed and developing nations (Fidancı & Yenil Taci, 2020). The implementation of this model served as a catalyst for a fundamental shift in the organizational structure of primary care.

In relation to the shift in the organizational structure of primary care, FM has been recognized as a medical specialty for over thirty years in Türkiye. Specialization training began in 1985 at hospitals in Ankara, Istanbul, and Izmir. The FM Specialization Association was founded in Ankara in 1990, and the first FM Journal was published in 1997. "Currently, there are 203 FM associate professors in Turkey, 87 of whom have been appointed as professors. In 86 FM training clinics approved by the Medical Specialization Board, more than 250 teaching staff and approximately 3750 assistants continue their education" (Erdem et al., 2023). This system provides nearly all preventive health care services in the country (Fidancı & Yenil Taci, 2020). The European Definition of General Practice/Family Medicine emphasizes that the discipline must be directly linked to the core competencies of general practitioners. These competencies include primary care management, person-centered care, specific problem-solving skills, a comprehensive approach, community orientation, and holistic modeling (Evans, 2023, p.8). Together, they reflect the multifaceted nature of family medicine, which simultaneously addresses health issues across physical, psychological, social, cultural, environmental, and existential dimensions, giving appropriate consideration to each aspect (Evans, 2023, p.11).

However, there are criticisms regarding the current frameworks guiding FM, particularly the one set forth by the WHO. According to Evans (2023), the WHO Framework does not adequately address the critical component of general practice: the individual consultation between patient and family doctor. Gay's theoretical model of general practice, known as the Global Model, integrates an open-minded approach that considers diseases as results of organic, human, and environmental factors. This holistic model aligns with Engel's BPS model, viewing health as a complex interplay of various factors (Evans, 2023, p.11).

For Turkish context, FM's defining characteristics include serving as the initial point of contact with the healthcare system, adopting a patient-centered approach, following a unique consultation process, and promoting continuity of care. Dr. Çisem Saygılı and Prof. Dr. Mehmet Ungan emphasize these aspects in their discussion on holistic approaches in FM. They argue FM has theoretically incorporated BPS

model. They highlight that FM integrates distinctive education, research, evidence-based practice, and primary care-oriented clinical expertise, as defined by the World Family Medicine Association (WONCA) in 2005. The core competencies for family physicians are management of primary health care services, original problem-solving skills, person-centered care, social orientation, a comprehensive approach, and approaching the person as a whole (Saygılı & Ungan, 2023). Despite being theoretically framed around the BPS model and holistic care, FM in Türkiye has not fully lived up to these ideals in practice. Öcek et al. (2014) found that family physicians in Türkiye have a limited role as the initial point of contact and in providing continuous, comprehensive, and coordinated care.FM system, in principle, is designed to offer patient-centered, holistic care but that the practical implementation is lacking. Their study concluded that the FM model does not offer an adequate framework for integrating healthcare services. This indicates a significant gap between theoretical models and their practical implementation. Nonetheless, the BPS model is not an unfamiliar concept within the context of FM in Türkiye, as highlighted by WHO and other relevant organizations.

In conclusion, while family medicine has a theoretical foundation supported by comprehensive frameworks like the BPS model, there is a need for further evaluation and improvement in its practical application, particularly in Türkiye.

3.4. Integration of TCAM in Türkiye

Conventional scientific medicine is increasingly challenged by traditional medicine (TM[125]) and alternative approaches. In 2002, WHO launched its first global strategy

[125] Traditional medicine, in the context of Türkiye, is also mentioned as 'ethnomedicine' or 'folk medicine' / 'folk healing' (halk tababeti/sağaltmacılığı) which refers to the oral knowledge that is formed by transferring knowledges and practices about health and disease from generation to generation as well as reproduction of it through this transformation. It may be defined as codified and regulated knowledge that is taught openly and practised widely, and benefit from thousands of years of experience (Sever, 2015, p. 181). According to Don Yoder, "folk medicine has organically been originated from the beliefs, morals, thoughts, lives and speeches of the public and it is the sum of curing methods being applied against diseases among people, as well as the traditional views about diseases" (Sever, 2015, p.183). Folk healing is divided into various branches. As Yoder (1975) indicates, these public treatment methods can be grouped by two main areas of application. The first is natural folk medicine which represents one of the first reactions of man to nature that utilization of various plants, minerals and animal materials to treat the disease. The second is religious-magical

on TM/CAM[126], promoting the integration of these practices into national healthcare systems (Holliday, 2003; WHO, 2002). This strategy influenced healthcare policies in Türkiye, formalizing the role of TCAM within the healthcare structure. The updated WHO strategy (2014–2023) further prioritized strengthening health services and systems by integrating TCAM products, practices, and practitioners (WHO, 2013).

The updated WHO strategy emphasized the need for regional adaptations, allowing Türkiye to customize its approach to TM within its specific cultural and historical contexts.[127] Cultural and historical contexts play crucial roles in how to implement TM in contemporary medical practices. For instance, Christopher Dole's work, In the Shadows of Medicine and Modernity, explores the historical role of TM in Türkiye, particularly its intersection with the development and modernization of a biomedically focused healthcare system. Dole highlights how the modernization of healthcare was part of a broader state project that sought to reshape notions of subjectivity and citizenship, often in opposition to cultural and religious practices[128] associated with TM (Dole, 2004).

> In addressing the question of why so many healers inspire antipathy (despite being frequently consulted), I am consequently taken into the role of

medicine, which draws on amulets, sacred words and the like in the treatment of illness (Yoder, 1975, p. 23; Kaplan, 2010).

[126] Complementary and alternative medicine (CAM) encompasses an array of medical and health care practices, systems, and products that are currently considered to fall outside the realm of conventional medicine (Briggs et al., 2011).

[127] According to the strategy document, the development process involved consultation with Regional Advisors for Traditional Medicine from the six WHO regions, as well as input from relevant technical units and departments within WHO. The strategy was further informed by reports from 129 countries and other relevant sources (WHO, 2013).

[128] The cultural and historical foundations of TM, often tied to mystical, communal knowledge systems and practical necessity can be explained as such: Sever (2015) emphasizes the mystical and secretive nature of TM, noting that it "may be highly secretive, mystical, and extremely localized, with knowledge of its practices passed on orally" (p. 181). Oral transmission across generations is thus a key characteristic of TM. According to Sever, traditional medical practices emerged as early reactions to natural events, with communities comparing and exchanging medical knowledge, often shaped by magical beliefs. He describes folk medicine as a response to both material and moral disorders from mythic times to the present. From another perspective, folklorists like P.N. Boratav argue that folk medicine arises when people cannot access doctors for various reasons (Tavukçu, 2015, p. 17). Moreover, in Türkiye there is a special branch of TM as Ocak System,in which there is a special healer for a specific disease and have a link with religious heritage (Tavukçu, 2016, p.42). These views together underscore the cultural and religious foundations of TM in Türkiye.

> medicine within the history of Turkey's modernization project and the sorts of cultural practices that became entangled within the project's expanding webs of signification. After considering the altered importance of biomedical services in the state's transition from the Ottoman Empire to the Turkish Republic and the countrywide expansion of biomedically based health care, I examine a popularly oriented, state-sponsored journal of the 1930s and 1940s called Ulkü to illustrate the ways in which medicine served to frame the proper role of the new state in the daily lives of its citizens and the ways in which it encoded notions of subjectivity and citizenship that this relationship would require. (Dole, 2004, p. 257)

The national development of the country and its medical system have become closely interconnected (p.260). Understanding this context is crucial because it sheds light on why TM, despite its frequent consultation, is often met with skepticism or hostility.

This historical perspective reveals how modernizing efforts in Türkiye aimed to integrate biomedical practices into the national healthcare system, framing TM as 'non-scientific' and thus a threat to modernity. This dynamic highlights the tension between modern healthcare developments and traditional practices, illustrating how historical and cultural factors influence current attitudes toward alternative medical approaches.

Integrating TCAM into conventional health care systems in developing countries requires different strategies than those used in developed countries (WHO, 2013). For instance, it is essential to initiate the integration process at the community level. This can be achieved by integrating practitioners of TCAM and allopathic health care professionals, fostering collaboration and mutual understanding among them (Mishra et al., 2015). A well-structured systematic review study highlights key components for integration as communication, patient-centered care, education, policy, and financial support (Negahban et al., 2018)[129].

[129] According to the review study, Elements of Integrating TCAM into Primary Healthcare: A Systematic Review, Integrating CAM into healthcare systems involves professional relationships based on mutual respect and clear protocols are essential. CAM should be integrated non-hierarchically with conventional medicine, considering cultural appropriateness and proper documentation. Education initiatives should raise public awareness and include CAM training in medical schools. Policies need government support and strategic planning, with CAM providers involved in policy making. Financial support should cover CAM therapy reimbursements, encourage provider participation, and allocate necessary resources (Negahban et al., 2018).

Recognizing the need for regional adaptations, the WHO strategy allowed Türkiye to tailor its approach to specific cultural and historical contexts.[130] Consequently, the WHO impacted Turkey's healthcare policy by promoting the inclusion of TCAM in national healthcare systems and encouraging the development of supportive policies for integration (WHO, 2002).

The WHO Strategy for TM was key in shaping Türkiye's healthcare policies by promoting the integration of TCAM into the national system. The Ministry of Health guided this process through surveys, adapting TCAM practices to the local context.[131]

Türkiye has enacted several policies aligning with the WHO strategy, such as the 1991 "Acupuncture Treatment Regulation" and the establishment of the Directorate of TCM Practices[132] in 2012. The 2014 Regulation on TCM Practices and the formation of the Türkiye Institute of TCM aimed to integrate evidence-based practices with modern medicine . By July 2018, 46 TCM application centers were offering various therapies. The 2014-2023 WHO strategy continued to shape Türkiye's approach, acknowledging the need for regional variations[133] to fit its cultural and historical context. The Ministry of Health has used surveys to refine TCM policies and ensure compliance with national regulations, reflecting Türkiye's commitment to the WHO Strategy (Arpacı, 2021; Şimşek et al., 2017; Dole, 2004). In order to do so, following the strategic plan, some state hospitals opened new

130 For instance, in Türkiye, TCAM practices are generally associated with the religious beliefs and values of consumers (Metin et al., 2019; Şimşek et al., 2017; Dole, 2004).

131 Organized by the Ministry of Health in cooperation with the WHO, the 2nd International TCM (GETAT) Congress started in 2019 under the auspices of the Presidency of the Republic of Türkiye.

132 The first regulation in the field of TCM was the "Acupuncture Treatment Regulation" in 1991, aimed at ensuring acupuncture treatments are conducted scientifically (Mollahaliloğlu et al., 2015). In 2012, the Directorate of TCM Practices was established under the Ministry of Health (Resmi Gazete, 2011). The Regulation on TCM Practices was published in 2014 (Resmi Gazete, 2014a), and the Türkiye Institute of TCM was established the same year to integrate evidence-based TCM with modern medicine (Resmi Gazete, 2014b). By July 2018, there were 46 TCM application centers within health research hospitals, offering treatments such as acupuncture, leech therapy, cupping, mesotherapy, prolotherapy, and ozone therapy (http://getatportal.saglik.gov.tr). Presidential Decree No. 1 in 2018 included provisions for regulating and supervising TCM practices (Resmi Gazete, 2018) (Biçer & Yalçın Balçık, 2019).

133 Türkiye is part of the European Region of the WHO.

departments as GETAT[134] under the 'Regulation of TCM Applications' which published in the official newspaper (numbered 29158) on 27 October 2014. Until today, according to the Ministry of Health, 75 GETAT Application Centers, Education Centers and Application Units have been founded by the TCM Practices Department[135]. Within the scope of the regulation, related to the establishment of GETAT Units, the standards have been determined in 15 different fields: 1-Acupuncture, 2-Hypnosis, 3-Apitherapy, 4-Phytotherapy, 5-Leech Therapy, 6-Cup Practice, 7-Reflexology, 8-Ozone Application, 9-Homeopathy, 10-Caryopractic Application, 11-osteopathy, 12-mesotherapy, 13-Music Therapy, 14-Prolotherapy, 15-Larva (Magot) Application.

Education level of the patients are said to play a significant role in the use of TCAM methods in the literature. Numerous studies have aimed to identify demographic traits and reasons why patients turn to TCAM. Some studies about diabetes patients in Türkiye and cancer patients in European and American context suggest a relationship between greater use of CAM and patients with higher levels of education (Ceylan et al., 2009; Molassiotis et al., 2005; Fouladbakhsh et al., 2005). Many studies show that TCAM use is higher among women with advanced education in high-income countries (Harris et al., 2012; Berthold et al., 2007; Mollaoglu & Aciyurt, 2013). In contrast, in low and middle-income countries, TCAM usage tends to be linked with individuals of lower educational and socio-economic backgrounds (Pearson et al., 2018; Bishop & Lewith, 2010; Lee et al., 2004; Liwa et al., 2014; Mekuria et al., 2017; Joseph et al., 2016). According to Mollaoğlu et al.'s (2013) discussion, in Asian populations, there is a connection between education and cultural influence, with less educated individuals often being more inclined to use alternative practices due to cultural factors. On the other hand, in Western populations, well-educated individuals tend to exhibit characteristics similar to "cultural creative persons" by actively exploring alternative approaches (p.185).

134 GETAT refers to the Integrative Medicine,Complementary, Alternative Medicine Application Units. You can reach to the regulation via http://www.resmigazete.gov.tr/eskiler/2014/10/20141027-3.htm

135 The Ministry of Health General Directorate of Health Services TCM Practices Department was established in 2012 under the Ministry of Health. See: http://getatportal.saglik.gov.tr/TR,8455/yonetim-semasi.html

In Türkiye, there are ongoing debates about integrating modern Western medicine with TM methods. These discussions are accompanied by objections from various quarters. A significant critique has come from the Turkish Medical Association (TMA)[136] The TMA has criticized the regulation and the Ministry of Health for creating departments (GETAT Units) dedicated to TCAM within hospitals. They argue that these units pose a threat to public health and represent a form of obscurantism[137].

In November 2017, the TMA published a book titled *There Is No Alternative to Medicine!* (In Turkish: Tıbbın Alternatifi Olmaz)[138] which defends modern medical techniques and philosophy while critiquing TM. This debate continues,[139] with contributions from medical professionals on both sides. Contrastingly, a MD of the newly established GETAT units has countered the TMA's position, supporting the scientific validity of TCAM methods in a newspaper article[140].

The debates in Türkiye around integrating modern Western medicine with TCAM highlight the tension between tradition and scientific rigor. While advocates push for blending cultural practices with modern healthcare, critics, like the TMA, raise concerns about safety and evidence-based standards.

136 The TMA, or Türk Tabipleri Birliği (TTB) in Turkish, is the organized voice of physicians in Türkiye, established in Istanbul in 1953 and relocating to Ankara in 1983. Its website is http://www.ttb.org.tr/index.php.

137 The statement of the Turkish Medical Association (15.12.2017). "Traditional, alternative, complementary health practices threaten community health!" See: http://www.ttb.org.tr/haber_goster.php?Guid=79c09656-e1a9-11e7-ae04-02a94b7a8425

138 U.S.Cong., Türk Tabipleri Birliği Halk Sağlığı Kolu. (2017). Tibbin Alternatifi Olmaz! Geleneksel Alternatif Ve Tamamlayici Tip Uygulamalari (pp. 1-303) (S. T. & N. E., Eds.) [Cong. Doc.]. Ankara: Türk Tabipleri Birliği Yayınları.

139 Many researchers have noted that modern medical professionals are often skeptical of the terms 'healing' and 'healers' in a scientific context, with these concepts rarely discussed within the medical community (Capra, 1982, pp. 135-136). This creates a perception that modern medicine is detached from a holistic view, treating "humans" more as experimental subjects. As a result, the divide between traditional and modern medicine continues to grow.

140 Lüleci, N. (December 2017). "Tamamlayıcı Tıp Uygulamalarının Geleceği". http://www.gunes.com/yazarlar/prof-dr-nurettin-luleci/tamamlayici-tip-uygulamalarinin-gelecegi-841585

Table 7. A List of Mostly Referred TCAM Methods and Altenrative Healing Practices

1) Acupuncture	2) Aleksander tech.	3) Anthroprophic m.	4) Aromatherapy
5) Ayurveda	6) Bach medications	7) Bio-feedback	8) Herbal Medicine
9) Bioenergetics	10) Bio-chemistry	11) Do-in	12) Hydrotherapy
13) Hypnosis	14) of hirudotherapy	15) Homeopathy	16) Chiropractic
17) Cup Therapy	18) Macrobiotic	19) Massage	20) Music therapy
21) Naturopathy	22) Negative ion t.	23) Orgone therapy	24) Osteopathy
25) Pattern therapy	26) Pyramid treat.	27) Psionik	28) Radiesthesy
29) Radionic	30) Reflexology	31) Color therapy	32) Rolf method
33) Voice therapy	34) Shiatsu	35) Healing	36) Yoga
37) Magnetic field theraphy (magnet t.)	38)Traditional Chinese medicine (TCM)	39) Tai chi	40) The Unani system of medicine

CHAPTER 4

ANALYSIS OF THE FIELD WORK: EXPLORING THE TURN TO TCAM

When all the cultural and relational aspects of menstrual pain and reproductive health related problems of women have been considered, I came to an understanding that although physical and psychological factors can be involved, women's menstrual problems and difficulties can be best understood by locating them in social and cultural context. Reproductive health and specifically menstruation related problems are not just a medical issue. The women who I have conducted interviews told me about their healing and treatment processes which contains over dominantly social-cultural topics such as the meaning attached to the women's menstruation and body, the culturally expected and accepted forms of woman's body and behaviors; relational topics such as their relationship with their own body, spouse, parents, friends as well as socio-psychological issues as feelings of fear and shame.

In this chapter, firstly I will trace the experiences, preferences among urban, highly-educated, professional, middle-class women in Türkiye who choose TCAM and alternative healing practices. First, I will present their health conditions in detail and then I will give space to their stories about their experiences of the pain and unresolved health problems concerning their reproductive organs, and their perceptions of the encounters with the medical doctors, gynecologists during the search for healing for their problems between the biomedical and holistic domain.

Although these explanations do not aim to objectively prove the advantages of TCAM - an aspect beyond the scope of this research- they offer a summarized version of the information shared by my interviewees about their general health, making it easier to track and readability. This analysis will delve deeper with tracing the trajectory of the experiences of women.

Table 8 provides an overview of the health conditions of interlocutors before and after the use of TCAM.[141] It compares their general health and reproductive health status at two different points.

Table 8. Condition of the Interlocutors' Health

Conditions of the Interlocutors' Health					
Name	Age	Past Health in General (Before TCAM)	Current Health in general	Past (Before TCAM) Reproductive Health	Current Reproductive Health
Gönül	52	poor	good	poor	good
Jale	43	poor	good	poor	good
Şükran	50	poor	good	poor	good
Nüzhet	39	poor	moderate	poor	good
Hayrün nisa	37	poor	good	poor	good
Hicran	38	moderate	good	poor	good
Aysel	40	moderate	good	poor	moderate
Safiye	39	moderate	moderate	poor	good
Nuran	61	moderate	good	poor	good
Tijen	45	poor	good	poor	moderate-good
Afet	45	poor	moderate	poor	moderate

141 Regarding overall health status prior to adopting TCAM, a significant proportion of participants described their health as suboptimal. Among the 18 respondents, 11 characterized their previous general health as poor, while 6 portrayed it as moderate. Only one participant mentioned their past health as moderate to good. Following their engagement with TCAM, noticeable improvements emerged: 12 participants now expressed having good general health, 4 described it as moderate, and only 2 remained in the moderate to poor category. In terms of reproductive health, similar improvements were observed after the use of TCAM. Initially, all 18 respondents articulated struggles with poor reproductive health. However, after incorporating TCAM practices, 14 women conveyed significant improvements, describing their reproductive health as good. Three participants noted a shift toward moderate to good reproductive health, and only one continued to describe her condition as moderate, highlighting overall positive changes.

Table 8. (continued)

Türkan	37	poor	good	poor	good
Cahide	43	poor	good	poor	good
Pakize	42	poor	moderate	poor	good
Emine	41	moderate /good	moderate	poor	good
Dilhan	39	poor	moderate	poor	moderate-good
Nermin	46	moderate /good	good	moderate /good	good
Leyla	43	moderate /good	moderate /good	poor	good

Before moving on to the account of the interlocutors, Figure 3: Examples of CAM Based on Type[142] shows a graph exemplifying TCAM methods, together with the health conditions that are claimed to be treated. The graphic highlights the interconnected nature of these treatments. As we will see in the following pages my interlocutors also mention several health conditions and a blend of different holistic methods and alternative healing practices in their healing journey. This graphic is a good example to show my argument that the relationship between holistic models and the BPS model that I discussed in detail in Chapter 3.2. While the BPS aspects are not explicitly mentioned in the graph, many TCAM methods align with the BPS model. TCAM predominantly employs holistic approaches, and the accounts of the fieldwork goes parallel with that women's use of alternative practices can be understood through the lens of the BPS model in their approach to interconnection of biological, psychological and social aspects of health and illness. My participants use a variety of TCAM and alternative healing practices or energy therapies. We can define alternative healing methods as accessible yet relatively new approaches that focus on the body and mind, distinct from more widespread and accepted practices like yoga, meditation, and psychotherapy. Energy therapy, mind-body interventions,

[142] Complementary and alternative medicine. Shiatsu Toronto. (2018, January 28). https://www.shiatsutoronto.org/complementary-and-alternative-medicine/

manipulative therapies, and biologically-based therapies intersect on various levels, making it difficult to clearly distinguish one type from another.Methods such as bio-energy, frequency therapy, breath-work, magnet therapy, Reiki, recall healing, quantum hypnosis, past life regressions, family constellations, and shamanic practices can be categorized under alternative healing practices group.

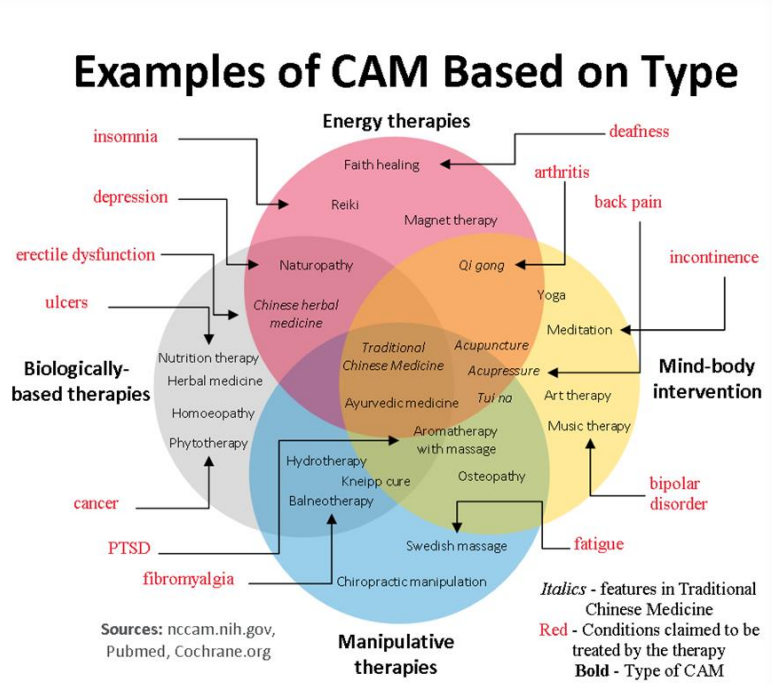

Figure 3. Examples of CAM Based on Type. Taken from *https://www.shiatsutoronto.org/complementary-and-alternative-medicine/*

4.1. Dissatisfaction with the Health Outcomes of Conventional Biomedicine

During my fieldwork, a recurring theme was the dissatisfaction with the health outcomes of conventional medical treatments highlighted by the women I interviewd in terms of the ineffective treatment and the negative and side effects. These topics, which emerged in my interviews, observations, and information-gathering sessions with TCAM practitioners, was the primary reason for seeking TCAM treatments. In this section, I will explore the different factors contributing to dissatisfaction with the health outcomes of conventional biomedicine.The dissatisfaction with biomedical health outcomes leads us to question how the modernist expectation of healing shifts into a holistic healing approach for women. We will explore which areas biomedicine fails to engage with and how a holistic

perspective translates and responds to these unmet needs, offering alternative forms of understanding and care. One of the interlocutors account provides many aspects for discussion:

> My main complaint was these pains that took me to the hospital every 2-3 months. They said that some of them were caused by polycystic ovary syndrome (PCOS). They suspected appendicitis. They suspected Mediterranean fever. Medications were prescribed. I was even diagnosed with stomach-intestinal infections and took unnecessary antibiotics. Finally, after 1.5 years, my appendix burst, and they said retrospectively, "Oh, it was appendicitis." But I think having PCOS greatly increased the pain. Anyway, what caused what... If you ask me now, I think it was all due to poor nutrition, eating pastries every day, terrible cheeses, terrible sugary foods. Both the PCOS and the appendicitis. If you ask me now, I think all my pains and cramps were caused by poor nutrition. I think both the female organs and the intestines were affected in parallel, both together. Modern medicine couldn't provide me with anything during that period - it couldn't offer a solution. They removed my appendix after it burst, but before that, there was no diagnosis or treatment for the pains.
>
> After the appendectomy, it seemed like I shelved my health problems as if they had passed. But since PCOS was still there, I started having very painful menstrual periods. Although it was not that painful at the beginning of university, by the end, I was taking 1-2 Majezik, sometimes 3, throughout the entire period. These pains kept increasing. I would go to the doctor, saying it hurts a lot. They would say, "You will take a painkiller, it is normal." I would say, but it hurts a lot, sometimes I vomit. I get such severe cramps in my abdomen. Is it this normal, I would ask? They would say, "Well, you have PCOS, pain is normal." How will it go away, I would ask? "Well, when you give birth, the body cleanses itself," they would say. It will go away then, they would say. So, how will I solve it if I am not going to give birth, I would ask. Modern medicine really lost me there by only recommending painkillers for my pains. Then I started researching alternative methods because my body was telling me that this was not a normal level of pain.[143] Nüzhet

143 The original Turkish version of the quote: benim temelde en önemli şikayetim bu sancılardı. 2-3 ayda bir beni hastaneye götüren. onların bir kısmının polikistik over'den kaynaklandığını söylediler. apandistten şüphelendiler. akdeniz ateşinden şüphelendiler. ilaçlar yazıldı. mide- bağırsak enfeksiyonu teşhisi bile konuldu. antibiyotikler falan kullandım gereksiz gereksiz. en sonunda 1,5 sene sonunda apandistim patladı. ve "aaa apandistmiş" dediler geriye dönük olarak. ama bence polikistik over olması ağrıları bayağı artırmıştır. zaten neyin neye sebep olduğu... şu an bana sorarsan aslında kötü beslenme, her gün poğaça yemek, berbat peynirler, berbat şekerli gıdalar yemekten kaynaklanıyor. hem pcos hem de apandistler. şu an bana sorarsan tüm o ağrılarımın sancılarımın kaynağının kötü beslenme olduğunu düşünüyorum. hem kadınlık organlarının hem de bağırsak ikisi paralel, ikisi birlikte etkilendi bundan diye düşünüyorum. bana o dönemde modern tıp bana bir şey veremedi - bir çözüm veremedi. apandisit patladıktan sonra aldılar ama öncesinde ağrılar bu yüzdendi, ya da o ağrılara yönelik bir tedavi falan olmadı.apandist ameliyatı sonrası bir anlamında askıya almış oldum sanki sağlık problemlerim geçti gibi. ama pcos orada durduğu için çok ağrılı regli dönemleri başladım. üniversite başı o kadar ağrılı olmamasına rağmen üniversite sonunda artık her 1-2 majezik

The excerpt outlines how Nüzhet, initially reliant on modern medicine, turned her back on it due to a series of misdiagnoses and inadequate treatments for her severe abdominal pains. Her doctors dismissed her intense pain as 'normal' due to PCOS and suggested that childbirth would eventually alleviate her symptoms. We actually witness the grandeur of the medical gaze which is the mentality that divides the body into organs, the body's communication into symptoms, and conditions into rules, shattering in an instant. As Baszanger (1998) opens up physicians prioritize biological processes at the cellular level in the body such as tissue damage, infections, and biochemical imbalances. This hierarchy reflects a historical bias in medicine as I discussed in Chapter 3. Here, we can relate the underestimation of the 'severe' pain by the doctor with the boundaries of the epistemological motives of symptomatic treatment, which is inherent to the biomedical model as discussed in Chapter 3.2.1.3. As medico-scientific gaze views the human body as an object of science, the human body is perceived as devoid of subjectivity or personal experiences. Although Nüzhet expresses her feeling of pain to her doctor, in doctor's mindset there seems no possibility to connect a relationship with the patients' experience. Rather, the doctor applies what the pre-determined boundaries of PCOS to the patient's situation. As long as Nüzhet has a diagnosis of PCOS, 'having severe pain' is perceived under the 'expected' result for the biomedical approach. The biomedical model has limitations to involve the experience of patient in the medical encounter. Doctor's role does not open a space to 'speak' with experience. While Nüzhet can not translate her bodily experience to the doctor's meaning set, she felt disappointment. The story of dissatisfaction with the health outcomes of conventional biomedicine represents the theme of disappointments. And in this particular disappointment, that is, in that dark point where the cold face of medical gaze's symptomatic classification reflects back to us as frustration and helplessness, a situation also occurs that shatters the exalted representation of the medical gaze.This is, in fact, a spectacle of its inadequacy.The point where the medical gaze

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,3 tane majezik içiyordum tüm period süresince. bu ağrılar giderek arttı. doktora gidiyordum. çok ağrıyor diyorum. "ağrı kesici alacaksın normal" diyor. "ama çok ağrıyor" diyorum "kusuyorum bazen". o kadar kramplar giriyor karnıma yani. "bu kadar normal mi" diyorum. "e pcos'un var ağrıması normal" diyor. nasıl geçecek diyorum. "e doğurunca temizleniyor zaten vücut, o zaman geçer" diyor. "e doğurmayacaksam nasıl çözeceğim" diyorum. **orada modern tıb gerçekten benim ağrılarıma sadece ağrı kesici önererek beni kaybetti yani.** sonra alternatif yöntemleri araştırmaya başladım. çünkü vücudum bunun bana normal ağrı derecesi olmadığını söylüyor. Nüzhet

fails to provide me with answers, where it disappoints me the most, is also the point where its attempt to be represented as a patrimonial/symbolic sublimity, that is, the point where the phantasmagoria of sublimity shattered.The assumptions underlying Western biomedicine have fostered an approach that treats disease as a distinct and separate entity within the body. In Nüzhet's case, we can see the traces of this perspective which views illness as an independent condition to be treated in isolation (Comaroff, 1982; Gordon, 1988). She reacts against to the 'objectification of patients' in the sense discussed in Chapter 3.2.1.3.

Amidst the background of her disappointments, Nüzhet engages with her body in a new way, *embodying* it differently and thus transforming from merely being classified as a 'patient.' She says "my body was telling me that this was not a normal level of pain". This shift allows Nüzhet to establish a nuanced *listening relationship* with her body, which can be seen as a form of connecting with her body and feelings. This new embodiment of her is quite different from the expectations of biomedical modern medicine's perception of the body. Feminist scholars like Rapp (1992) and Chrisler (2004) analyze how medical practices and health discourses impact women's experiences of their bodies. Here, Nüzhet's embodiment is in transformation which creates practical advantages in her treatment since she starts directly connecting with her body. Building connection with the body is one of the most referred themes in women's healing. For instance, Dr. Christiane Northrup's groundbreaking book "Women's Bodies, Women's Wisdom" emphasizes the natural wisdom and healing capacity of the female body. Northrup (2010) advocates for a holistic approach to women's health, encouraging women to develop greater awareness of their bodies. She argues that women should reconnect with their bodies, understand their hormonal cycles and emotional states. In essence, she advocates for trusting the inherent wisdom of the female body and empowering women to take control of their health decisions. Nüzhet's case as listening to her body as her body indicated that the pain she was experiencing was not *normal*[144] and taking the control of her health decisions is in parallel with Northrup's point.

[144] The normalization of menstrual pain will be analyzed in Chapter Five. For details see 5.1.1.2. The Hidden Epidemic: Under-Diagnosis of Menstrual Pain.

Frustrated by the lack of effective solutions and dismissive attitudes, Nüzhet felt abandoned by modern medicine, “modern medicine really lost me there by only recommending painkillers for my pains”. This experience prompted her to seek alternative methods. This shift draws attention to the terrain of the potential of change that occurs when expectations are disappointed. This shift in perspective also highlights critical issues within modern medical practice, such as the risk of misdiagnosis, over-reliance on medications, and the perception of the patient as an object as I discussed in Chapter 3.2.1.3. Nüzhet’s story emphasize her need for a more holistic and attentive approach to patient care. Her expectation is to get a medical appointment that considers the patient’s subjective experiences and symptoms[145] rather than just prescribing standard treatments.

Nüzhet’s new way of embodiment experience creates her some advantages to understand her health and illness conditions better. Together with the shift in her paradigm in approaching her body, and with the trial of certain foods in her diet, she makes a reasoning as “I think all my pains and cramps were caused by poor nutrition. I think both the female organs and the intestines were affected in parallel, both together” (From interview). If we consider that her ability to make this inference is the result of the 'listening' relationship she has developed with her body, then what allows her to enter this new realm of embodiment is the previous paradigm shift in Nükhet’s life perspective. This paradigm shift of her is actually the story of the paradigm shift that I had previously narrated on a more theoretical and historical level in Chapter 1.4 and Chapter 3.4 , on another scale. Thus we can trace this transformations as one of the micro-macro scale shifting channels.

Moreoever, unlike the biomedical approach’s advice to use painkillers, she her reasoning aligns with Devroede’s concept of ‘cloacal thinking’ (p. 142), which serves as a conceptual tool for exploring the connection between early life traumas

[145] Their common point is that the difference between conventional medicine and the TCAM methods lies in the philosophy that guides the approach to chronic symptoms. “When a patient has experienced long-lasting or recurring symptoms, conventional medicine does not tend to address the underlying cause. The focus is instead on the symptoms, and treatment is often geared toward turning those symptoms off. Conventional medicine will often treat symptoms such as indigestion, bloating, poor focus, fatigue, rashes, and recurring pain with anti-inflammatory medications, acid blockers and antacids, stimulants and steroids” (Morrison, 2018).

and the development of gastrointestinal and pelvic floor dysfunctions in patients (Devroede, 2000). Devroede's idea of 'cloacal thinking' offers a holistic perspective on the body, challenging the conventional view that it is made up of distinct, isolated parts that can be treated independently in medical practice. Instead, cloacal thinking emphasizes the interconnectedness of the body's systems and functions, drawing insights from fetal physiology (Sullivan, 2015, p. 76). This framework encourages a more comprehensive understanding of the body, urging medical professionals to consider the complex relationships among various organs and systems when diagnosing and treating illnesses.

Another participant briefly explains her preference for TCAM as follows:

> The facilities provided by the state are limited. The hospitals are very crowded. I generally get outpatient treatment from nearby polyclinics, of course. But for much more important things, like my gynecological exams, I have never gone to a state hospital. Because at the private hospital, I have a doctor that I have become accustomed to and who knows my body. So I did not want to change that. I get my annual check-ups done privately. They are covered by insurance anyway. They have routine check-ups. For my doctor appointments, I still go to my private doctor. It has been a long time, about 20 years, that I have been seeing the same doctor for gynecology.[146] Nuran

This excerpt highlights a common issue faced by many participants: the disparity in the quality of care between state-provided and private medical services. Nuran mentions the overcrowded nature of state hospitals, which often leads her to seek outpatient treatment at nearby polyclinics. The familiarity and continuity of care provided by a private doctor, who has been treating her for 20 years, offer a sense of comfort and trust that is lacking in the state system. Here, beyond the ease of access to private services due to class privilege, there is something more here: Nuran's primary reason for preferring a private doctor over a state doctor stems from the fact that Western biomedicine has become disconnected from people. She wants to see a

[146] The original Turkish version of the quote: Yani devletin vermiş olduğu imkanlar belli. Hastaneler çok kalabalık ki … Ayakta tedaviyi artık genelde yakındaki polikliniklerden alıyorum tabii ki. Ama hani çok daha önemli mesela jinekolojik muayenelerim hiç devlette gitmedim. Çünkü orada (özel hastanede) hani şeyi artık alıştığım ve benim bünyemi tanıyan doktorum var. Dolayısıyla onu değiştirmek istemedim yani. Yani o yıllık kontrollerimi özelde yaptırıyorum. Yani özelde zaten sigorta kapsamında oluyor. Onların rutin kontrolü var. Doktor muayenelerimde yine özeldeki doktoruma gidiyorum. Jinekoloji için işte bayağı oldu. Yani 20 yıldır aynı doktora gidiyorum. Nuran

doctor who knows her personally, who perhaps is familiar with her past medical history and way of life, and knowing that the doctor gives him/her time during appointments affects her choice. In this sense of familiarity and continuity, there is something deeper that feels different -something that could also be connected to holistic medicine. It feels more alive. As emphasized in the holistic approach, the patient's personality, psychology, and social and cultural existence are critical to health, beyond just their biological symptoms. For example, this can be linked directly to technopolitical critiques; the familiarity here, through its constancy, enables the recognition of ontological difference. Nuran wants to be seen in her wholeness and uniqueness, which serves as a response to the objectification of patients within the medical system.

> Other than that, for more general issues, for example, I go to get my general tests done. Of course, during this time, I go to the local polyclinic. I get consultation from the relevant doctor there. But unfortunately, as you know, functional medicine services are not provided in the state hospitals. Regarding that, since I prefer a functional medicine doctor for general health consultations, I currently find conventional medicine to be very deteriorated and distant from the human aspect.
>
> I: Can you access functional medicine doctors in private hospitals besides conventional medicine?
>
> I have never gone to a functional medicine doctor in a private hospital, to be honest. Actually, it is nice that you asked this because I am considering changing my functional doctor. Maybe since they are becoming more widespread now, there are definitely doctors in hospital settings that I can access. Because they are becoming more common.[147] Nuran

Altough there are newly opening GETAT units in public hospitals in the last decade, this is not widely known by the respondents. One reason for this is that not all public

[147] The original Turkish version of the quote: Onun haricinde ama daha genel mesela genel tahlillerimi yaptırmak için gidiyorum. Tabii ki bu arada semt polikliniğine gidiyorum. Oradaki ilgili doktordan şey alıyorum. Mutlaka danışmanlık alıyorum ama maalesef biliyorsun devlette fonksiyonel tıp şeyi hizmet verilmediği için.Onunla ilgili de yine yani sağlıkla ilgili genel danışmanlığı da ben fonksiyonel tıp hekimini tercih ettiğim için. Yani ciddi anlayışım çerçevesinde klasik tıbbı şu an çok bozulmuş, insandan uzak buluyorum çünkü.
Ben: Özel hastanede klasik tıp haricinde fonksiyonel tıp doktorlarına ulaşım sağlayabiliyor musun?
Özel hastanede fonksiyonel atıp hekimine hiç gitmedim. Açıkçası. Şöyle esasında bunu sorman da bir yandan da güzel oldu. Çünkü fonksiyonel hekimimi değiştirmeyi düşünüyorum. Belki şimdi giderek yaygınlaştığı için hastane bünyelerinde de ulaşabileceğim hekimler mutlaka ki olmuştur. Çünkü yaygınlaşıyorlar. Nuran

hospitals have GETAT units; and if one is opened, there is limited choice.[148] Nuran's preference, yet like every preference, it is the echo of an experience, and in her set of experiences there is a tremendous amount of expectation and disappointment. She emphasizes the importance of continuity in care, mentioning that she has been seeing the same gynecologist for 20 years, which highlights her desire for a trusted and personalized healthcare experience. This continuity is something she finds lacking in public hospitals, which she perceives as overcrowded and unable to offer the specialized care she needs. When her speech continues, I start to see that her main point is not making a distinction between public and private healthcare systems. She brings up the topic to the 'functional medicine'. Her preference for a functional medicine doctor is rooted in her belief that conventional biomedicine has become "deteriorated and distant from the human aspect."

Functional medicine, which focuses on holistic, patient-centered care, aims to address the root causes of diseases rather than just treating symptoms. Functional medicine generally refers to TCAM methods and for Nuran, it represents a more comprehensive health approach. This perspective suggests a desire for a healthcare approach which considers the physical, psychological and social aspects of humans, aligning with her dissatisfaction with the more segmented and impersonal nature of conventional biomedicine. Nuran's critical view of conventional biomedicine is evident in her statement that it has become very "deteriorated" and "distant from the human aspect." What could be the meaning of being distant from the human aspect? As a discussion point we can continue with Gönül's account below.

> I went to a professor for this urinary tract problem because it wasn't going away. Then he said it was something called '*interstitial cystitis*.'[149] In other words, it is considered an unknown pelvic pain. After that, the doctor told me,

[148] For example, in Ankara, Mustafa Kemal State Hospital provides ozone therapy and cupping services, while Murat Erdi State Hospital provides cupping and acupuncture services. And during pandemic, the GETAT unit of Mustafa Kemal Hospital had closed to spare place for Covid polyclinics.

[149] Interstitial cystitis is a medical condition marked by pelvic pain, urgent and frequent urination, and nighttime urination. Diagnosing interstitial cystitis can be challenging because its symptoms are similar to those of many other common gynecological and urological disorders. As a result, patients with undiagnosed interstitial cystitis may undergo unnecessary procedures, such as hysterectomies (Chung & Jarnagin, 2009).

> "I have good news and bad news. The good news is you're not going to die." I tell this story a lot (her voice is frustrated and shocked). They took a biopsy from my bladder because they suspected it might be cancer. Then the doctor said, "The bad news is you're going to suffer." For a doctor to say something like that… This man was a professor at Marmara University, and he said this to me. After that, my perspective on doctors changed a lot. I started looking into alternative medicine because, with such an attitude from doctors, how are you supposed to get better?[150] Gönül

Gönül's experience with the doctor's dismissive tone ("you won't die, but you'll suffer") is a vivid example of the disconnect from human aspect, and the objectification and the dehumanization often criticized in biomedicine. The use of authoritative language and a lack of compassion in the communication with patients is seen as reducing patients to mere bodies with symptoms, rather than individuals with emotions, personal histories, and dignity. This is echoed in critiques of the "*doctor-as-authority"* model, where the patient is often seen as a passive recipient of medical knowledge, rather than an active participant in their care (Lupton, 1994). The doctor's casual attitude toward Gönül's suffering exemplifies this disconnect, leading her to lose faith in the biomedical system.

The diagnosis of "interstitial cystitis" as an 'unknown pelvic pain' speaks to the limitations of biomedicine in fully understanding and addressing complex, chronic conditions that do not fit neatly within diagnostic frameworks. This aligns with broader critiques of biomedicine's reductionist approach, which often isolates specific symptoms or organs rather than considering the patient holistically. Gönül's frustration reflects the inadequacies of biomedicine in addressing not only the physical but also the psychological and emotional dimensions of illness. As Sullivan (2001) suggests, by failing to account for these broader aspects, biomedicine risks alienating patients, particularly women, whose pain and symptoms often remain unexplained. Gönül's experience mirrors Baszanger's (1998) observation of the

[150] The original Turkish version of the quote: Idrar yollarındaki bu sorun için profesöre gittim, çünkü geçmedi bu. Ondan sonra dediler ki "bu interstisyel sistit" diye bir şey dediler. Yani bilinmeyen pelvik ağrı diye geçiyor bu. Ondan sonra bana doktor işte dedi. "Bir iyi haberim var, bir kötü haberim var, iyi haberim ölmeyeceksin" yani bu hikayeyi çok anlatıyorum (sesi hüsrana uğramış ve şok olmuştu). idrar kesemden parça aldılar orada kanser mi var acaba diye şüphelenildi de. Ondan sonra "kötü haberim sürünüceksin" dedi. Yani bir doktorun böyle demesi… bu adam Marmara Üniversitesi'de profesördü, bunu bana dedi. Ondan sonra zaten benim doktorlara bakış açım çok değişti. Yani alternatif tıbba bakmaya başladım. Çünkü doktorların bu bakışıyla nasıl iyileşeceksin yani? Gönül

hierarchical nature of medical explanations. Baszanger highlights that physicians often prioritize cellular pathology—the physical and biological processes at the cellular level—over psycho-social circumstances. Cellular pathology, being concrete and measurable, is considered more significant in the diagnostic and treatment process. In contrast, psycho-social factors, which encompass psychological, social, and environmental influences, are deemed less significant or even dismissed (Baszanger, 1998). Gönül's experience reflects this hierarchy; the emphasis on the biological aspects of her condition, coupled with the stark prognosis, leaves her feeling alienated and unsupported. This medical approach contrasts with the holistic care she seeks, reflecting a broader trend where patients turn to alternative medicine in response to dissatisfaction with conventional approaches. This shift is common among women patients who feel unheard or mistreated within the conventional medical system. Similarly, research shows that TCAM often provides patients with a more holistic and personalized approach to health, focusing on emotional, social, and spiritual aspects of well-being (Broom & Tovey, 2008). Gönül's turn to alternative medicine reflects a desire for more patient-centered care. Gönül's account also fits within a technopolitical critique of biomedicine, where technological interventions, such as unnecessary biopsies or tests, are often prioritized over patient well-being. The suspicion of cancer and subsequent biopsy, despite the diagnosis of interstitial cystitis, illustrates how biomedicine can sometimes lead to excessive and invasive procedures without necessarily addressing the root cause of the patient's condition. Technopolitical critiques often argue that this approach reflects the broader capitalist and institutional pressures within healthcare, where efficiency and profit sometimes overshadow the patient's lived experience and holistic care (Clarke et al., 2003).

Her story highlights not only the frustrations stemming from the uncertainties in conventional diagnoses but also the profound impact that clinical communication can have on a patient's trust in the medical system. This case invites a closer examination of how the modernist expectation of healing transitions into a holistic expectation, a theme explored further in subsequent sections.

Another significant factor contributing to dissatisfaction with biomedical treatments is the negative and side effects highlighted by the women I interviewed.

You will need to go to the bathroom 30-40 times a day. You will not have a normal social life. You will not have a normal sex life, and you will experience burning and pain after every sexual encounter. These are the things he (doctor) said. So, he prescribed another antibiotic. I think my intestines were ruined during that period because of the medication. We just did not know what to do and followed his instructions. He even brought a heavy medication from Germany. When I took it, it made me feel dizzy—maybe it contained anesthetic or narcotic. It felt more like a depressant, something that numbed me. I used it for a month. Then I stopped. It wasn't going to work, it just couldn't. I mean, such a thing is impossible,(with surprise and anger) it could not be like this.[151] Gönül

While the modern pharmaceutical industry and conventional medicine have been widely praised for their success in treating acute and infectious diseases, growing concerns are emerging about the adverse effects and side effects associated with biomedicine. Gönül's experience highlights a harm that goes beyond what is typically considered a "normal" side effect, reflecting the broader issue of the potential long-term damage caused by pharmaceutical interventions. Functional nutritionist Susan Wyler and Dr. Thomas Rau, who practiced as a medical doctor in the USA and Switzerland for 35 years before transitioning to holistic disciplines like Traditional Chinese Medicine and Ayurveda, emphasizes that while modern medicine has made great strides, many patients endure significant harm from long-term drug use, surgeries, and other conventional treatments. They observes that many patients, after years of treatment with drugs, surgery, or radiation, often experience minimal real benefit and, in many cases, suffer from unintended consequences of biomedical interventions (Wyler & Rau, 2014).

The concept of iatrogenesis, introduced by Ivan Illich in his 1976 book "Medical Nemesis," encapsulates the risks to human health posed by medical practice itself.

[151] The original Turkish version of the quote: Günde 30 -40 kez boyuna tuvalete çıkacaksın. Ondan sonra normal bir sosyal hayatın olmayacak. Normal bir cinsel hayatın olmayacak, her cinsellikten sonra böyle işte yanmalar, sızılar olacak. Böyle şeyler söyledi? Evet işte. O yüzden ıı (duraksıyor) işte yine o da bir antibiyotik ilaç dayadı. Bence bağırsaklarım da ondan sonra böyle bozuldu benim o dönem, işte biz de bilmiyoruz. O kadar çok şey … dediklerini yapıyorduk. Hatta bir de Almanya'dan bir ilaç getirtmişti. Almanya'dan bir ilaç, ağır bir ilaç. içince böyle kafam dönüyor gibiydi. içinde belki uyuşturucular da vardı. Daha çok depresyon, uyuşturan gibi bir şeydi bence öyle bir şeydi. Yani uyuşturuyordu insanı. onu bir ay kullandım. sonra bıraktım. Olmayacaktı(hayret ve sinirle), bu olamaz yani öyle şey. Gönül

Michael Mann defines iatrogenesis as the detrimental effects of medical intervention, both as a professional practice and as a social ideology. the term "iatrogenesis" as denoting "the risks to human health and wellbeing of the power of medicine as professional practice and as social ideology in contemporary society. Iatrogenesis takes three forms. Clinical iatrogenesis refers to the risks associated directly with medical therapy itself" (Mann, 1983, p.163).

Mann identifies three forms of iatrogenesis: clinical, social, and cultural. Clinical iatrogenesis refers to the direct risks associated with medical therapy, such as side effects and complications from surgery and drugs. Illich and Mann argue that doctors often cause disease and suffering through aggressive and impersonal technological treatments, and through the side effects and accidents associated with unnecessary medical interventions.

Beyond clinical iatrogenesis, social and cultural iatrogenesis highlight the broader implications of the medicalization of life. Mann summarizes Illich's criticism of modern medicine as such:

> He asserts that doctors cause disease and suffering, either directly through the aggressive and impersonal resort to technological treatments, or indirectly as the side effects and accidents associated with unnecessary surgery and drugs. But clinical iatrogenesis is only one dimension of the problem; even more significant are the social and structural forms of doctor-induced suffering, disease and disability. These are respectively the result of the medicalization of life brought about by both the spread of medical ideology and treatment to all spheres of life, and the destruction of pre-existing cultural modes of coping with pain, suffering and death, through the imposition of a common medical culture which aims to anesthetize all sensation and feeling. (1983, p.163)

Social iatrogenesis refers to the proliferation of medical ideology and treatment into all aspects of life, while cultural iatrogenesis denotes the erosion of traditional ways of coping with pain, suffering, and death. Illich argues that the imposition of a standardized medical culture seems to seek to numb the forms of sensation and emotion, resulting in a type of suffering caused by medical professionals that goes beyond the physical realm. Moreover, the pharmaceutical industry's focus on symptom management rather than curing illness is another critical issue. In many

cases, pharmaceutical treatments do not address the root causes of diseases but merely reduce symptoms. This symptomatic approach can lead to a reliance on medication, perpetuating the belief that recovery is unattainable without pharmaceutical intervention.

Various studies on CAM have revealed several motivations for people choosing these therapies. These reasons include the presence of side effects from conventional treatments, the challenges associated with managing chronic conditions, the absence of a complete cure, the perceived inadequacy of conventional treatments, and the belief in the naturalness and effectiveness of CAM approaches" (Arı & Yılmaz, 2016; Sultan et al., 2008; Roy et al., 2015).

One of the interlocutors, Şükran (age 50) have irregular menstruation and later diagnosed with PCOS. She mentions that the side effects of the medication treatment given to her for irregular menstruation are unbearable. She first visited the gynecologist due to her irregular menses. When she was 15 years old, her mother took her to the doctor. Şükran's case is an example for the long use of pills without curing the core problems. She used the pills for about 15 years till she was 32 years old. After this age, she started to seek for holistic medicine methods.

> Şükran: I think it was in the second year of middle school. Because I had a very irregular period, I would have my period and then not have it for two months. Since I had always had such a problem since my adolescence, I didn't really know what a routine was, how heavy the bleeding should be, what the color should be, or the frequency. My mom took me to a hormone doctor, a gynecologist, and they diagnosed me with polycystic ovary syndrome (PCOS) there.
>
> Me: How old were you?
>
> Şükran: About 15.
>
> Me: You mentioned irregularity, can you elaborate a bit?
>
> Şükran: It was irregular. I didn't have my period for a very long time. When it didn't happen, I just ignored it. I had no awareness of my cycle. Months would pass, and I would wonder if I was having my period or not. Is this how it is for women? (rhetorical question). I didn't have much knowledge. It was a dark bleeding, not bright red, more like a dark spotting. I wasn't sure if it was

a period. I didn't really share it, it just passed and went. Many years went by like this. Then the doctor tried to regulate it with birth control pills and hormone pills.

Me: How did you first go to the doctor?

Şükran: My mom took me. She had obviously realized the irregularity. We went to the gynecologist. I used a drug called Yasmin, I remember it very well. And since I hadn't had my period for a long time, there was a short-term medication, I don't remember the name, but it was a 6-day pill that made me have my period suddenly. I don't know its name. It was meant to solve the issue quickly. Since I hadn't had my period for 2-3 months, it was probably a progesterone-heavy pill. I was expected to take it for 6 days and have my period within 3-5 days.

Me: How often did you use the 6-day medication?

Şükran: Well, not regularly. We would wait and wait, and when it didn't happen for such a long time, the doctor would say, "Let's give this medication." I remember it made me incredibly irritable psychologically. I remember crying one day because I couldn't take the medication anymore. After that, we switched to birth control pills.

Me: How did you share this with the doctor?

Şükran: I said it was making me irritable. I couldn't recognize myself. There were such drastic mood swings. Initially, I didn't realize it was because of the medication, but later on, I felt something was seriously affecting me. I was very irritable. My eating habits were disrupted. There was something I couldn't understand. The doctor said this medication might be causing it. To regulate my periods, they suggested that birth control pills would be more suitable. That's how I started using Yasmin.

Me: How long did you use Yasmin?

Şükran: Very long. Many years, I mean (said with weariness). I used it almost until 2012. Finally, a gynecologist told me that this medication shouldn't be used for such a long time. Because it actually poses a risk to the cardiovascular system. There could be issues related to blood clotting in the future. They especially recommended sports.

Me: So, you used birth control pills for about 15 years?

Şükran: Yes, about 15 years. Not continuously. There were times when I stopped. I would take a break to try to relieve my body, and when it didn't work, I would start again.[152]

[152] Şükran: sanırım orta 2 idi. çok düzensiz bir adet durumum olduğu için, oluyordum sonra 2 ay olmuyordum. genç kızlığımdan itibaren hep böyle bir problemim olduğu için, nasıl bir rutin var,

Another participant directly indicated side or adverse effects[153] even before asking her about it. Gönül shared that she witnessed a woman friend from the same group experiencing very serious health problems as a result of misdiagnosis or wrong biomedical treatment.

> There are these trainings. I heard about this rule from my friends in education. From friends in the Breath group. So we were keeping each other informed

---

kanamanın yoğunluğu nasıldır, rengi nasılsır? sıklığı nasıldır? pek bilgi sahibi değildim açıkçası. annem beni bir hormon doktoruna, kadın doğum doktoruna götürmüştü. orda polikistik over dendi.
Me: kaç yaşındaydın
Şükran: 15 filan
Me: düzensizlik dedin, açar mısın biraz
R: düzensiz oluyor. işte çok uzun zaman zaten olmuyor. olmayınca zaten bırakıyorum. farkında bile değilim. döngü farkındalığım yoktu. aylar geçiyor aaaa oluyor mu olmuyor muyum, böyle mi oluyor kadınlarda? (retorik soru). pek bilgim yok. koyu bir kanama geliyor ama parlak bir kan değil de, koyu bir lekelenme geliyordu. adet midir bu nedir. öyle bir farkındalığım yoktu. onu da paylaşmıyordum pek, geçiyor gidiyordu. uzun yıllar böyle geçti. sonra da bana doktor doğum kontrol hapı vererek bunu düzenlemeye çalıştılar. ve hormon hapları ile başladı.
Me: doktora ilk gitme sürecin nasıl oldu?
Şükran: annem götürmüştü. yani bu düzensizlik olduğunu tabi anlamıştı. kadın doğuma gitmiştik. yasmin diye bir ilaç kullandım hiç unutmuyorum. bir de uzun bir süre adet görmediğim için, kısa süreli olan, ismini hatırlamıyorum ama, 6 günlük bir ilaç içilip bir anda adet olunmasını sağlayan bir laçtı. bilmiyorum ismini. ama hızlıca çözmek için. 2-3 ay olmadığım için, sanırım progesteron yoğun bir hap olabilir. onu 6 gün süre ile içip, 3-5 gün içinde adet görmem bekleniyordu.
Me: 6 günlük içilen ilacı ne kadar sıklıkla kullanmıştın
Şükran: valla onu. düzenli bir şekilde değil. bekliyoruz bekliyoruz olmayınca, bu kadar uzun süre olmayınca o zaman bu ilacı verelim (diyor doktor). o ilacın ben de cok ciddi anlamda psikolojik olarak anormal sinirli yaptığını hatırlıyorum. bir gün gerçekten ben bu ilacı içemiycem diye ağladığımı hatırlıyorum. ondan sonra doğum kontrol hapına geçmiştik.
Me: doktorla bunu nasıl paylaştınız?
Şükran: sinir yapıyor. ben kendimi tanıyamıyorum. o kadar duygu durum değişikliği oluyor ki. önceleri bunun ilaçtan kaynaklı olduğunu da anlamamıştım ama sonrasında gerçekten beni bir şey çok etkiliyor. çok sinirleniyorum. yeme düzenim bozuluyor. ne oldugunu anlayamadığım bir şey var. doktor da buna bu ilaç sebep olabilir demişti. adetlerimi daha düzenli hale sokabilmek için o zaman doğum kontrol hapının daha uygun olacağını söylediler. yasmine geçişim böyle oldu.
Me: yasmini ne kadar sürek ullandın
Şükran: çok uzun. çok uzun yıllar yani (bıkkınlık ile söyledi). nerdeyse 2012'ye kadar kullandım yani. en sonunda bir jinekologum da dedi ki bu ilacın da bu kadar uzun süre kullanılmaması gerekiyor. çünkü kalp damar sistemini de aslında riske atan bir durum. kanın pıhtılaşması ile ilgili bir sorun yaşanabilir ileri ki zamanlarda. özellikle onlar sporu önermişti.
Me: doğum kontrol ilacını 15 sene gibi mi kullanmış oldun
Şükran: evet 15 yıl gibi. sürekli demeyeyim. biraz bıraktığım da olmuştu. ara verip biraz rahatlatmaya çalışıyorum vücüdumu, olmayınca tekrar başlıyordum.

[153] Many women experience symptoms during peri-menopause, and Hormone Replacement Therapy (HRT) is frequently prescribed to help manage these symptoms (Guthrie et al., 1996) However, despite its effectiveness (MacLennan et al., 2001), numerous women choose to refuse or discontinue HRT due to side effects such as vaginal bleeding, bloating, and breast tenderness, or concerns about an increased risk of cancer and other conditions associated with HRT (Regan et al., 2001; Ettinger et al., 2003).
Consequently, a significant number of women are turning to safer alternative therapies to alleviate their symptoms and enhance their quality of life (Newton et al., 2002; Keenan et al., 2003; Factor-Litvak et al., 2001; Gollschewskiet al., 2004; Sluijs van der et al., 2007). Many of these alternative treatments fall under the category of Complementary and Alternative Medicine (CAM).

about what was happening. We were going through similar processes. They were also curious about such alternative solutions. I think we lost our faith in doctors. for that reason… For example, what do I know? There was someone who was a psychologist. They removed her gallbladder. After her bile was removed, the girl did not recover. What was done wrong? I mean, I don't know what stomach aches are. Now they are going from doctor to doctor. They are tryin to resolve this with alternative ways.[154] Gönül

4.2. Dissatisfaction with the Medical Encounter or Doctor-Patient Relationship

This section will deal with how doctors treat women in their one to one private sessions. Two main themes emerged as sexist and misogynistic behaviors and attitutes of doctor that the women I interviewed mention about the lack of respect they felt during their encounters.

Nüzhet: What always convinces me is... How do I decide if a view or method is good? Only by experimenting on myself. Nothing else can convince me. Not someone's explanation, but I need to see it myself. If I hadn't noticed relief after three months on the first diet I tried, I would have said, "This guy said 'mambo jumbo'[155] stuff, and I tried it." When I see the effect by trying it, I realize it is not mambo jumbo. That is how I get convinced. My mind opens up, I become more open-minded by experimenting. Unfortunately, due to the attitudes of the doctors, I could not trust what they said. I had to do the experiments myself.

Nüzhet: Endo bursts like an appendix rupture. The blood inside spreads, and it needs to be cleaned. You need to have surgery within a day, just like appendicitis. If that man (the doctor) had treated me a bit more reasonably, I would have used the medication, and my endometriosis would not have burst, and I would not have needed surgery.

I: Do you believe this?

Nüzhet: I think if that man had behaved a bit more pedagogically, approached me gently, he could have convinced me to use the medication. I didn't go

[154] Işte bu eğitimler var ya. bu kural dışı eğitimdeki arkadaşlardan duydum. Nefes grubundaki arkadaşlardan. Yani birbirimizi haberdar ediyorduk olan şeylerden. benzer süreçlerden geçiyorduk. Onlar da meraklılardı böyle alternatif çözümlere. galiba doktorlara olan inancımızı kaybetmiştik. o yüzden. Ne bileyim mesela. Psikolog olan biri vardı. Safra kesesini almışlar. Safrası alındıktan sonra kız iflah olmadı. Yanlış mı yapılmış ne. Yani mide ağrıları bilmem ne. şimdi doktor doktor dolaşıyorlar. Alternative yollarla işte bunu çözümlemek için. Gönül

155 Here "mambo jambo" refers to something that is considered nonsense, gibberish, or meaningless talk. It implies that if the method or advice had not worked, Nüzhet would have dismissed it as baseless or unreliable information.

there because I was determined not to use the medication. After all, I went to that doctor because he is a medical expert. He could have convinced me. If he had said, "Look, I know there are such studies," he could have convinced me to use the medication.
Researcher: Are there any cases where medication has cured endometriosis that you know of?

Nüzhet: No, it doesn't cure it. But it does prevent its growth when you're on medication. For example, at that time, my cyst was around 4 cm. They can measure it with ultrasound. When you take medication, it suppresses the formation of the uterine lining every month, so the cyst doesn't grow. The cyst stays the same size. The thing that makes the cyst grow is the monthly period, where the uterine lining grows and as it grows, the cyst grows too. During menstruation, the uterine lining is shed and resets to zero. But the cyst doesn't shed; it remains and continues to grow. What the medication does is keep it stable. It does not cure it, but it might prevent it from bursting.[156]

Nüzhet did not use the medication initially recommended by her doctor primarily due to the doctor's approach and behavior towards her. Nüzhet went to the doctor with the intention of relying on his expertise and was open to being persuaded about the medication. However, the lack of a considerate and informative discussion led her to lose confidence in his advice. Additionally, the conversation between Nüzhet and her doctor lacks the scientific explanation, which was expected by Nüzhet but the doctor refused to give a scientific medical explanation for the acceptable duration of

[156] Beni her zaman inandıran şey. bir görüşün, bir metodun iyi olup olmadığına nasıl karar veriyorum. kendi üstümde deneyerek sadece. başka birşey beni ikna edemiyor yani. birinin açıklaması değil de ben onu görücem yani .ilk yaptığım diyette 3 ay sonra rahatlama tespit etmeseydim, bu çocuk mambo cambo bir şeyler dedi ben e bunu denedim diyecektim. deneyip de etkisini görünce onun mambo cambo olmadığını gördüm. öyle ikna oluyorum yani. kafam açılıyor open-minded a doğru gidiyorum deneyerek. ve denerken malesef doktorların tutumları nedeniyle onların söylediklerine güvenemedim. kendim yapmam gerekti deneyleri.
Nüzhet: apandit patlaması gibi endo patlıyor. içindeki kan yayılıyor falan temizlemeleri gerekiyor. bir gün içinde ameliyat olman gerekiyor. aynı apandist gibi. aslında o adam (doktor) bana biraz daha makul davranmış olsa o ilacı kullanacaktım ve endometriosisim patlamayacaktı ve ameliyat olmam gerekmeyecekti."
Ben: buna inanıyor musun ?
Nüzhet: bence o adam biraz pedegojik davransaydı, bana yumuşak yaklaşsaydı, beni ilaç kullanmaya ikna edebilirdi. Ben o zaman kesinlikle ilaç kullanmıycam diye gitmedim. sonuçta adamın bilgisine güvenerek gittim yani, sonuçta tıp uzmanı diye gittim. beni ikna edebilirdi. bak biliyorum şöyle çalışmalar var deseydi. beni ikna edebilirdi aslında ilaç kullanmaya.
Ben: ilaç kullanıp da endo'yu geçiren vaka var mı, biliyor musun?
Nüzhet: hayır. geçirmiyor. ama buyümesine engel oluyor ilaç kullandığın zaman. yani mesela benim o dönem 4 cm falandı kist. ultrasonda ölçebiliyorlar. ilaç kullandığın zaman her ay rahim iç duvarının yapılışını baskıladığı için kist büyümüyor. kist aynı boyutta kalıyor. kisti büyüten şey her ay period görüp rahim iç duvarının büyümesi, o büyürken kist de büyüyor. regl olurken rahim iç duvarı atılıyor sıfıra dönüyor. ama kist atılmıyor. orada kalmaya ve büyümeye devam ediyor. ilacın yaptığı şey onu sabit tutmak. yani iyileştirmeyekti ama patlamayacaktı belki.

the medication, instead he refers to “until you have a child”. The ambiguity left her feeling helpless when she was leaving the doctor’s room. This reminds Ivan Illich’s criticism of medical culture that the enforcement of a standardized medical culture seeks to numb all sensations and emotions, resulting in a type of doctor-induced suffering that goes beyond just physical pain (1983). This is so familiar to me; I have witnessed this scene firsthand many times, just as I have heard it from different women who have experienced similar situations.

Nüzhet shares a distressing encounter with a doctor (gynecologist) whose misogynistic behavior left her feeling angry and desperate. The doctor’s dismissive and condescending attitude towards her concerns about hormonal medication highlights the presence of sexism within the medical field.

> I was diagnosed with endometriosis. It took two years to get the diagnosis. And the doctor I went to at that time also made some mistakes. I experienced a lot of discomfort due to a personal issue with the doctor. Endometriosis, also known as a chocolate cyst, was the reason I went to see this doctor. We were discussing what needed to be done. He said, 'We need to suppress your cycles. You'll need to use birth control pills.' But I didn’t want to take any chemicals. I had a principle against taking oral pills. I told him, 'I don't want to take hormonal medication. How long will I have to use it? Can you explain the treatment process to me?' He casually said, “Until you give birth.” I responded, “But you didn’t ask if I want to have children. How could you make such a plan on your own?” I was asking how long it is healthy to use the medication, but he persistently didn't tell me the maximum healthy duration for its use. He kept saying, 'You are already 27 years old. You will give birth in 5 years.' I said, “You are a doctor, you are risking my life. If I do not have children for 10 years, is it healthy to use this medication for 10 years? That is what I'm asking.' idiot. Then the doctor said, 'My sister-in-law is also doing her doctorate. She also says career first,' and he said, 'Imagine you have a website. Would a picture of a woman with her family, children, and a dog look better, or a picture of a single woman?' He was implying that a picture of a single woman was undesirable. I asked, 'Are you telling me to have children because of social pressure?' He said, 'No, it is not social pressure. But in 5 years, you'll be desperate for children.' He was basically a bully. I left the room, feeling very angry and desperate.[157] Nüzhet

[157] endo teşhisi kondu. 2 sene sonra kondu. ve o sefer gittiğim doktor da yanlış bir şeyler yaptı. doktorla yaşadığım kişisel sorundan dolayı çok rahatsızlık yaşadım. endometriosis, çikolata kisti demek. bu sebepten gittim bu doktora. doktorla konuşuyoruz. ne yapmam gerek. senin döngülerini baskılamamız lazım. doğum kontrol hapı kullanacaksın dedi. bense kimyasal almak istemiyorum. ağzımdan hap girsin istemiyorum. böyle bir prensibim vardı. adama ben hormon ilacı almak istemiyorum dedim. ne zamana kullanıcam, tedavi sürecini bana anlatır mısınız dedim. sanki dünyanın

In this excerpt, Nüzhet recounts her troubling experience with a doctor whose misogynistic behavior left her feeling angered and desperate. The doctor's dismissive attitude towards Nüzhet's concerns about hormonal medication is a harsh example of misogyny in the medical field.[158] He not only failed to respect her but also imposed his own beliefs about women's roles and reproductive decisions. His casual assertion that Nüzhet should use birth control pills "until you give birth" closes the possibility of a dialogue about the treatment.[159] The doctor's insistence that Nüzhet, at 27 years old, would inevitably want children within five years and his refusal to provide information on the long-term health implications of the medication demonstrates a profound lack of respect and empathy. Furthermore, his analogy comparing the appeal of a woman's image with or without a family on a website underscores his reduction of a woman's value to her reproductive choices and familial status. Nüzhet as a mechanical engineer, was doing a Phd and working at a high status position at a company. The doctor's attitude not only undermines Nüzhet's professional and personal aspirations but also perpetuates stereotypes that women are incomplete or less valuable without children.

Nüzhet's response to the doctor's behavior is a mix of anger, frustration, and helplessness. She felt belittled and invalidated by someone she sought out for professional help. The doctor's inability to provide a supportive and understanding environment pushed Nüzhet to seek alternative treatments, highlighting a significant failure in patient care. This experience not only eroded her trust in conventional

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en doğal şeyini söyler gibi, "doğurana kadar " dedi. ben de, "ama bana doğurup doğurmayacağımı sormadınız ki" dedim. "nasıl böyle bir plan yapabildiniz kafanızdan". Ben soruyorum ilacı kullanmak ne kadar süre sağlıklı. adam bana ısrarla ilacı kullanmak için maksimum sağlıklı süresini söylemiyor. ısrarla şeyi söylüyor. "zaten sen 27 yaşındasın. 5 seneye doğurursun" diyor. "sen doktorsun hayatımı riske atıyorsun. 10 sene doğurmaycaksam 10 sene bu ilacı kullanmak sağklıklı mı onu soruyorum" gerizekalı. Ve doktor "benim, dedi, görümcem de doktora yapıyor. o da senin gibi önce kariyer diyor", bak dedi, aynen bunu söyledi. "şimdi bir web sitesi yaptıgını hayal et. orda ailesi ile birlikle çoluklu çocuklu köpekli bir kadın resmi mi daha iyi durur dedi yoksa kuru bir kadın resmi mi" dedi. kuru bir kadın resmi diyor. "siz bana sosyal baskı nedeni ile çocuk yapmamı mı söylüyorsunuz" dedim. "yok sosyal baskı değil de. siz öyle konuşursunuz ama 5 sene sonra görürüm ben seni, çocuk çocuk diye deliriyorsunuz" tarzı konuşuyor. resmen bluuy (zorba) çıktı. ben de çıktım odadan. ve çok sinirli ve çaresiz çıktığımı hatırlıyorum. Nüzhet

158 As another example, I was advised by at least 5 different gynecologists as "PCOS would go away when you got married" at different times over 15 years. another doctor said "If you had had children by now you wouldn't be dealing with this. In this period, women avoid giving birth to children, but to what extent?" From my fieldwork diary.

159 In chapter 2 on women's embodiment I discussed this issue.

medicine but also underscored the importance of a compassionate, patient-centered approach in healthcare. Her story serves as a reminder of the need for sensitivity, respect, and comprehensive communication in the patient-doctor relationship. Her expectation of sensitivity implies a breakdown of the traditional medical gaze in patient interactions. Sensitivity in this context involves recognizing and validating the patient's subjective experience and emotional state. Doctors are called to attune to the nuanced ways in which patients communicate their symptoms and concerns, beyond mere clinical facts.

It also sheds light on the broader issues of gender bias as we discussed in Chapter 2, there is a high gender bias in medical research. She continues by indicating how her search for alternative treatment methods had started:

> The man I went to for help, educated, paid, from Başkent University, a serious place. (in an angry tone)
>
> I: Was it a private hospital?
>
> Nüzhet: Yes. I went to this particular doctor because my friend Başak recommended him. Her endometriosis had burst. This man operated on her and was a successful doctor. Her ovaries were tangled, and he didn't remove the ovary but solved the problem there. Out of respect for that, I went to this doctor. But he turned out to be a misogynist. I went home and decided I wouldn't use this medication. That's where my turn to alternative methods began. My search started there. Because of that man's behavior. My intention was to solve it with conventional medicine when I went to him. When he treated me like an animal, I thought, okay. Then I decided to find out why this problem was happening. My brain is doing this. The brain gives all the commands. If I can prevent my brain from giving that command to the ovary, maybe I can solve it. How can I hack my brain? By noticing and observing my thoughts. At that time, I was not conscious about emotions. That's why I am only talking about thoughts. So, my thoughts are creating this.[160] Nüzhet

[160] Yardım etsin diye gittiğim adam, eğitimini almış, parasını verdiğim, başkent üniversitesi. ciddi bir şey. (öfkeli bir ses tonu ile)
Ben: özel hastane miydi?
Nüzhet: evet. özellikle bu adama gittim. çünkü Senem diye bir arkadaşım önermişti. onun endometriosis patlamıştı. bu adam onu ameliyat etmişti ve başarılı bir hekim. yumurtalıkları dolanmış Senem'in. ve yumurtalığı almamış da, ordaki sorunu çözmüş. buna saygımdan bu doktora gittim. ama doktor kadın düşmanı çıktı. sonra eve gittim. bu ilacı kullanmayacağım dedim. işte orda benim alternatif yöntemlere yönelmem başladı. arayışlarım burada başladı. o adamın şeyi üstüne. ben normal tıp ile çözmekti niyetim bu adama giderken. o bana hayvan gibi davranınca tamam dedim. o zaman ben bu sorunun neden kaynaklandığını bulayım. bunu beynim yapıyor. beyin veriyor bütün komutları. demek ki beynimin o komutu vermesini engellersem yumurtalıga, belki çözebilirim. beynimi

Nüzhet's desires and expectations resonates that she convinced that the entire medical system owed her a debt of life, which can be read as a form of bio-political governmentality in itself. Her expectation is to be treated with respect. Foucault's concept of pastoral power and its evolution into modern governmentality can be useful to understand her expectation and disappointmnet. Pastoral power, originating in Judeo-Christian traditions, involves the guidance and management of individuals by authority figures (Oliveira, 2020). This concept has been adapted in contemporary governance, where experts and professionals act as 'pastors' guiding self-governing subjects (Waring & Latif, 2017). The shepherd guiding his flock, characterized by gentleness, was presented as a genealogy of a form of governmentality, Nüzhet's desires, and expectations from doctor and medical encounter are exactly fit to this. I do not think she believed that all doctors owed her a debt of life through a self-originating will. This is a mode of thought very much tied to the last century, and even more specifically to the last 50 years at most. Also, she blames her illness and doctor on the fact that she was not treated gently. This is directly related to concepts like agency, responsibility, power, governmentality, and subjectivity, all central to Foucault's work.

However, the doctor's misogynistic behavior, dismissive attitude, and lack of respect for her autonomy shifted Nüzhet's approach to her treatment. She decided to abandon the conventional treatment plan that had been recommended. Before coming to this decision, Nüzhet had gone to the gynecologist many times between the ages of 18 and 27, both for menstrual pain and to an internal medicine doctor for unspecified abdominal and pelvic pain. Before she was diagnosed with endometriosis, she had accidentally undergone an appendectomy. She had used birth control medication for a year before her diagnosis of endometriosis. and when the doctor said that she should use the same medication again, she needed additional information on whether to continue the medication. Considering all these, we can better understand her desire to get information from the doctor about the progress of the treatment and her disappointment. This negative encounter catalyzed her decision to explore alternative

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nasıl hack'liycem. Düşüncelerimi farkedersem ve gözlemlersem. o zaman ben duygu konusunda bilinçli değildim. O yüzden sadece düşünce diyorum o sırada. benim düşüncelerim bunu yaratıyor demek ki.

methods. The doctor's inappropriate conduct and the lack of empathy he demonstrated made her question the effectiveness of biomedicine for her situation. This experience prompted her to take control of her own health and seek out alternative treatments that aligned more closely with her principles and beliefs.

Her story is significant to underline that the impact of the patient-doctor relationship on treatment decisions is very crucial. When patients feel respected and heard, they are more likely to trust and adhere to medical advice (Govender et al., 2022). Conversely, when they feel dismissed or mistreated, they may seek out alternative paths that offer a sense of agency and respect for their personal values.

Another important point to underline here is the self-prescription of TCAM by women. Nüzhet's first trials were detox and dietary therapies were self-prescribed. Later, she consulted massage therapist, osteopath and energy healers again as a self-prescribed decision. The use of TCAM among women with reproductive issues, particularly self-prescribed, is a critical yet under-researched area. Nüzhet, like other interlocutors, decided to apply some alternative methods without professional guidance and without getting any help from medical doctors.[161] Self-prescription of CAM by women dealing with reproductive health problems reflects a significant gap in the conventional healthcare system. Women often turn to CAM therapies such as herbal remedies, acupuncture, and dietary supplements when they feel that conventional medical approaches have not adequately addressed their needs or when they seek more holistic and personalized care.[162]

> My diagnosis of endometriosis might have been in 2011. Even after being diagnosed with endometriosis, I kept going to doctors, still experiencing pain.

161 This knowledge is crucial for developing more comprehensive and integrative healthcare strategies that acknowledge and incorporate CAM practices safely and effectively. By doing so, healthcare providers can improve patient outcomes, enhance patient satisfaction, and foster a more collaborative doctor-patient relationship.

162 Understanding the decision making processes and experiences of these women is essential for several reasons. First, it sheds light on the motivations behind their choice to self-prescribe CAM, which include dissatisfaction with conventional treatments, a desire for more natural or holistic approaches, or cultural and personal beliefs about health and healing. Second, exploring these experiences can reveal the perceived benefits and challenges associated with CAM, such as relief from symptoms, empowerment through self-care, or potential risks and side effects.

> They kept saying it would get better once I got married. One doctor said something… As I'm telling you this now, I realize that what pushed me away was actually **the doctors' lack of respect for womanhood.** The first thing they ask is, "Are you sexually active?" Directly. First, they should prepare the woman. They should say, "Look, I'm going to ask you a personal question, and I want you to feel comfortable answering it. Like you did at the beginning of our conversation to make me feel comfortable talking. The doctor should tell me, "I'm going to ask you a personal question, but you can be open with me. I won't tell anyone your answer, so you can be open with me." If they don't explain this and ask abruptly, you panic.[163] Nüzhet

Another interlocutor, Tijen clearly explains why she has turned toward the search for treatment out of biomedical model. She says, "Net bir karar verdim. Bu konu araştıracağım diye."

> Tijen: I made a clear decision. So that I will never expose myself to such doctors again.
>
> I: Was there anything specific that triggered this decision?
>
> Tijen: Something happened, what was it? (thinking) I think my father had a friend. He was a doctor. I was suffering from menstrual pain when I went to Izmir on holiday one summer. And I was trying to figure it out. I think I asked that person. "I am experiencing something abnormal. What do you think?" That doctor did no't say anything like go and look at this. Ultimately, what did I do? I typed it on Google :) "I suffer from menstrual pain a lot, wondering if this is normal". There was nothing that triggered me other than normal doctors not being able to help.[164]
>
> …
>
> The spiritual maturity of the doctor is important here. It's not about whether they practice Eastern or Western medicine, but rather seeing the patient as a

[163] endometriosis teşhisi 2011 olabilir. endo teşhisi konunca yine doktorlara git, yine ağrılı geçiyor. yine evlenince geçer demeler falan. bir doktor şey dedi. ya aslında şu an sana anlatırken farkediyorum ki beni iten şey bu doktorların kadınlığa saygı duymaması aslında. en başta "ilişkin var mı?" diye soruyor. direk. önce bir hazırla kadını. yani de ki "bak şimdi sana özel bir soru sorucam. ve bunun cevabını verirken rahat ol gibi. senin bu görüşmenin başında yaptığın gibi... benim rahat konuşabilmem için doktorun bana demesi gerekir ki "sana özel bir soru sorucam ama bana açık olabilirsin. ben kimseye söylemiycem bunun cevabını, o yüzden bana açık olabilirsin." demesi gerekir mesela. bu açıklamayı yapmadan dangadak sorarsa sen panik oluyorsun. Nüzhet

[164] Tijen: Net bir karar verdim. Bir daha bu gibi doktorlara kendimi maruz bırakmayacağım diye.
Ben: bu kararı tetikleyen bir şey oldu mu spesifik?
Tijen: ya bir şey olmuştu, neydi? (düşünüyor) babamın bir arkadaşı vardı doktor. bir yaz tatilde İzmir'e gittiğimde, ben bu regl ağrısı çekiyordum. ve bunu çözmeye çalışıyordum. sanırım o adama sormuştum. "ya ben anormal bir şey yaşıyorum. nedir sizce?" falan diye. o doktor da git de şuna bak demedi. (herhangi bir yönlendirme yapmamış doktor) Eninde sonunda ben ne yaptım? google'a yazdım :) "regl ağrısı çok çekiyorum bu normal mi?" diye. normal doktorların yardım edememesi haricinde beni tetikleyen bir şey olmadı.

person and evaluating them objectively, making them feel accepted. No matter who you are, you should feel that you are accepted without judgment. This mindset of non-judgment is what's truly needed. The lack of that is what pushed me away from modern medicine.[165] Emine

…

The doctor didn't even say anything scientific. He just said, "You'll have to take this medication until you get married." Well, maybe I won't get married until I'm 60. Some people say, "It will go away after you give birth," which is actually better. But he told me it would go away when I got married (she laughs ironically). Is he assuming that once I have sex, everything will get better? It really confused me, maybe even harmed me. I wasn't in a relationship at the time. So, do I need to have sex? Is something supposed to happen when a penis enters? It made me think, should I go sleep with someone? He was basically saying, "You need to get married."[166] Hicran

When I first heard it, I didn't pay attention. It's the kind of thing an old lady on the street might say, or my aunt, who only finished primary school, would say, "Once you get married, you'll feel better" (meaning the pain will go away). When the doctor said it too, I thought, "What nonsense." Years and years passed, and I kept researching these topics. Then I thought, "Were you overlooking something, Hayrünnisa? What are the doctors trying to tell you?" Because I was so desperate, trying to find a solution for my problem. In the end, he's a doctor, so he must know something, right? I really wanted to trust him. But while I was going through it, I wondered if I was resisting something. Now, looking back, I get really angry. …

The way doctors speak disrespectfully about your personal life and womanhood.[167] Hayrünnisa

…

[165] doktorun ruhani gelişmişliği burda önemli oluyor. yani aslında okuduğu şeyin doğu tıbbı batı tıbbı olması değil de. insana insan olarak bakması ve seni objektif olarak değerlendirmesi ve bu kabul hissettirmesi. sen kim olursan ol benim kabulümsün hissini vermesi gerek. yargılamadan. yargılamama kafası aslında gerekli olan şey. ve onun olmaması beni modern tıptan uzaklaştıran şey oldu. Emine

[166] aslında doktor bilimsel bir şey de söylemedi. evleninceye kadar kullanacaksın bu ilacı dedi. belki de 60 yaşına kadar evlenmeyeceğim. bazılarına "doğurunca geçer" diyorlarmış. o yine daha iyi. bana evlenince geçer demişti. (ironik bir şekilde gülüyor). o da, şeyi mi varsayıyor? ilişkiye girince düzelecek diyor belki. benim kafamı çok karıştırmıştı. sakatlamıştı belki de. o zaman hayatımda kimse yoktu. benim cinsellik mi yaşamam gerekiyor? oraya penis girdiği zaman bir şey mi yapıyor: bu düşünceyle o zaman gidip birisiyle sevişmem gerekiyor diye bir düşünce veriyor. evlenmen gerekiyor dedi resmen. Hicran

[167] bunu ilk söylediklerinde, umursamadım. bunu sokaktaki teyze de söyler, ilkokul mezunu teyzem de evlenince rahatlarsın diyordu (yani ağrıların azalır). doktor da bunu söyleyince ne saçmalıyor diyordum. aradan yıllar yıllar geçti, bu konuları araştırmaya devam ediyorum. sonra dedim ki sen bir şeyi mi gözardı ediyordun Hayrünnisa. ne anlatmaya çalışıyorlar doktorlar sana. çünkü o kadar çaresiz bir şekilde derdime derman bulmaya çalışıyorum ki. bu da doktor sonuç olarak, bir bildiği vardır. cidden güvenmek istiyordum. olayın içindeyken, ben kendim bir şeye mi direnç gösteriyordum dedim. şu an bakınca çok kızıyorum. … doktorların senin özel hayatına ve kadınlığına saygısızca konuşması. Hayrünnisa

> Why is it that when we talk about biology and medicine, suddenly it shifts to a cultural or social issue? Why are we suddenly talking about marriage? When you're in the doctor's office, no matter who you are or where you come from culturally, you're just asking for help. And then they turn around and say something that makes you feel bad in a social context. "Oh, you're not married, that's why," or "You don't have kids, that's why." What does that have to do with anything? Just do your job. This is actually a form of bullying.[168] Nüzhet

> …
> I cried when I left the room. Here I am, at my age, without kids, not married. So, does that mean those with kids don't experience this? It feels like I'm being punished for something. Of course, these are thoughts I created myself, in a way. But what triggered it… They say, "It will go away once you get married." It made me think about so many things, like maybe I'm in pain because I'm not married. When you go to a dentist, if they need to pull a tooth, they just do it. I expect the same kind of distance in treatment. But at the same time, because the issue is sensitive, I expect them to act like a psychologist.[169] Türkan

In the above excerpts from the participants provide rich material for understanding how women's embodied experiences are disregarded in the medical system. Through themes like testimonial injustice, gendered medicine, and the doctor-patient power dynamic, we can see how the authority of biomedicine intersects with cultural and patriarchal expectations, leading to a form of gendered marginalization in health care. Women's narratives reveal the need for a more empathetic, non-judgmental, and holistic approach that respects their knowledge of their own bodies. In these accounts, the women's experiences of pain (such as menstrual pain) are dismissed, minimized, or not taken seriously by medical professionals. This leads to a disembodiment or a disconnect between women and their bodies. For instance, the biomedical approach to 'numbing' pain without addressing the underlying cause can cause women to feel alienated from their emotional and physical selves, which will

[168] evlenince geçer demesi. niye, biyolojiden tıptan bahsederken, niye bir anda toplumsal kültürel bir şeye gidiyor. niye evlilik diye bir şeyden bahsediyoruz bir anda. insan doktorun odasında kim olursa olsun, kültürel yapısından bağımsız olarak bir yardım istiyor. ve o kalkıyor seni sosyal alanda kötü hissettirecek bir şey söylüyor. evli değilsin de ondan diyor, çocuğun yok da ondan diyor. ne alakası var. işini yap. bunlar aslında bullying. Nüzhet

[169] ağladım ben odadan çıkınca. kaç yaşıma geldim çocuğum yok, evlenmedim zaten, çocuğu olanlar demek bir şey yaşamıyor. bu ağrıyı çekiyorsun sanki bir şeyin cezasını çekiyorsun. tabi bunlar benim kendi kendime üretmiş olduğum şeyler bir yerde. ama bunu tetikleyen...bana evlenince geçer diyor. evlenmemiş olduğum için bir sürü şey düşündürttü. bir diş doktoruna gidince diş çekilecekse çekiyor. aynı mesafeyi yapabilmesini istiyorum. aslında bir psikolog gibi de bakmasını bekliyorum konu hassas diye. Türkan

be mentioned in the following section where I discuss women's healing stories show they rebuilt a new relationship with their bodies in order to feel it again. In other words, the women has gone through a healing journey in which they start over to connect with their bodies and emotions by overcoming the numbness. This reflects a gendered experience of health, where women's embodied experiences are either pathologized or trivialized.

These excerpts shed light on the power dynamics inherent in the doctor-patient relationship as discussed in the Chapter 3.2. The authority of the doctor is emphasized by the participants, as seen in the repeated advice to "get married" or "have children" as a solution to women's health issues. These advises reflect a paternalistic approach where doctors assume authority not only over the body but also over the personal and social lives of women. This advice reinforces the notion that doctors possess a form of **epistemic authority** over women's bodies in patriarchal societies. Moreover, the recurring theme of "get married" or "have children" to resolve medical issues demonstrates **gendered medicine** at play. In this perspective, women's health problems are linked to their reproductive roles, reinforcing traditional gender expectations. The reduction of women's health issues to reproductive status shows a sexist framework where the complexity of women's health is simplified to social roles like marriage or motherhood. I critically discussed the reduction of women's reproductive health issues to reproductive status in the chapter 1.5. The Significance of Study. This reductionism has showed itself as the overemphasis on the birth control in approaching to women's reproductive health research and policies. Misogyny is present in the dismissiveness, disrespect, and reductive treatment of women's health concerns. Doctors' comments about marriage and children not only trivialize the women's health issues but also reinforce a misogynistic view that women's bodies exist primarily for reproductive purposes. This trivialization can lead to harmful outcomes, such as Hicran questioning whether she should "go sleep with someone" to solve her medical issue, illustrating how deeply internalized and damaging these interactions can be. In a similar way, the bullying described by Nüzhet, where doctors blame her health issues on her unmarried or childless status, further emphasizes the power of medical professionals to enforce social norms through their medical authority, leading to feelings of

inadequacy and distress among the women. Safiye tells about her first visit to a gynecologist when she was 19 or 20 years old. She indicates that she had been having severe abdominal pains and due to her pain she had to go to the emergency unit:

> My cousin took me there, my aunt's son. And the doctor asked me something like, let me see if I remember: "Can we do an internal ultrasound?" And he asked it in this way. How should I know? I said, "Why are you asking me about the method?"' It turns out they were trying to find out if I was a virgin. Because if you are not a virgin, they can do an internal ultrasound, I understood this later. They can see the cyst better from inside. The way the doctor asked this question really irritated me. And at that time, I was still a virgin. I was around 19 years old. I also had a boyfriend, but we hadn't had intercourse. When he asked me that question, I said, "I do not have a relationship." But I did not feel good, maybe you call it intrusive. It was a strange question. Actually, I remember something like this: that question came up there. After all, I had gone there in great distress. My aunt's son had taken me to the hospital. We had gone for an unrelated reason and I was directly asked such a question. If I had had (sexual) intercourse, I could not say it in front of my aunt's son. I could not lie to the doctor either. And I dodged a bullet in my own way. Later on, I remember telling my boyfriend: "Good thing we haven't had intercourse because they asked me this in front of everyone. And I wouldn't have been able to lie at that moment. I would not have known what to do."... The doctor didn't say, "This is private, only I will know." HE ASKED DIRECTLY (with emphasis, showing her shock). When he asked directly, I kept silent because I thought he would tell my cousin. Even if there wasn't anyone else around, I kept silent.[170] Safiye

The doctor's behavior in this excerpt reflects a significant breach of patient privacy. By asking such a sensitive and personal question in a direct manner, especially in the presence of a family member, the doctor failed to create a safe and confidential

[170] kuzenim götürmüştü o zaman beni. teyzemin oğlu götürmüştü. ve bana şey sordu doktor. ne dedi dur bakayım: "alttan ultrason yapabiliyor muyuz?" diye sordu. ve bu şekilde sordu. ben ne biliyim. "bana neden metodu soruyorsunuz" falan dedim. meğer şeyi sormaya çalışıyorlarmış. bakire olup olmadığımı öğrenmeye çalışıyorlarmış. çünkü bakire değilsen ultrasona sokuyor. içerden bakınca kisti daha iyi görebiliyorlarmış. doktorun bunu soruş şekli beni çok irite etti. ve o dönem bakireydim hala. işte 19 yaşında falandım. erkek arkadaşım da vardı, ilişkiye girmemiştik. bana o soru gelince, ilişkim yok dedim. fakat çok şey hissetmemiştim, intrusive mi denir. şey bir soruydu yani. hatta şöyle bir şey hatırlıyorum. o soru geldi orda. sonuçta can havli ile gitmişim. teyzemin oğlu beni hastaneye götürmüş. alakasız bir şeyden dolayı gitmişiz ve bana direk böyle bir soru soruluyor. orada ilişkiye girmiş olsam teyzemin oğlunun yanında diyemem. doktora yalan da söyleyemem. ve orda yırtmıştım kendi çapımda. sonrasında gidip erkek arkadaşıma gidip şey dediğimi hatırlıyorum: "iyi ki ilişkiye girmemişiz çünkü herkesin içinde bana bunu sordular. ve ben o zaman yalan söyleyemezdim. ne yapacağımı bilemezdim" dedim. … bana doktor "bu özel bir şey, bunu sadece ben bilicem" demiyor ki! DİREK SORUYOR YANİ (yaşadığı şoku vurgulayan bir ses tonu ile). Direk sorduğu zaman doktor kuzenime söyler diye sustum. etrafta başka insan olmasa bile sustum yani. Safiye

environment for Safiye because in patriarchal societies sexual intercourse is not talked openly with the relatives, especially male relatives. Medical professionals are expected to approach intimate health matters with discretion and sensitivity, ensuring that the patient feels respected and secure. The lack of consideration for privacy in this case not only caused discomfort but also undermined the trust between the patient and the doctor. Safiye's concern about her cousin potentially learning about her virginity highlights the additional layer of anxiety and embarrassment caused by the doctor's approach. This fear of judgment or gossip within her family could have been avoided if the doctor had handled the situation with more tact and respect for her confidentiality. **Sexism** in these narratives is evident in the ways doctors impose cultural and social judgments on women, rather than focusing solely on medical care. Nüzhet's reflection on why her health conversation shifted to social expectations around marriage demonstrates how medical consultations become sites of cultural reproduction, where patriarchal values are reinforced rather than challenged.The mismatch between women's health needs and medical responses demonstrates a disconnect in the biomedicine model, which fails to account for the lived experiences of women.The dissatisfaction with biomedical treatment suggests an underlying critique of how biomedicine often fails to handle women's reproductive health. The spiritual maturity of doctors, as mentioned by Emine, touches on the need for a more humanistic and compassionate approach, where patients are seen as whole individuals rather than just as bodies to be fixed. I want to share a case that perfectly illustrates this issue. I will present an excerpt from my field notes: In the Waiting Room of the Gynecology Department.

I'm waiting in the hospital corridor for my turn. It's a private hospital, and I'm about to meet with one of Ankara's most reputed gynecologists. As I wait for my appointment, I feel a bit nervous because I haven't had a period for five months now. Every month, I've been coming to the hospital for blood and hormone tests. Over the past 3-4 years, I've visited both public and private hospitals, consulting with various specialists. Upon a friend's recommendation, I've now come to this private hospital because I haven't received any viable solutions from other hospitals, aside from suggestions to use birth control pills or artificial hormone support. The common advice given to me was that the issue might resolve itself once I get married in the

future. Finally, my appointment time arrives, and I enter the consultation room. Despite being in a private hospital, I find that three patients, including myself, are in the room. Two other women are speaking with the doctor's assistant, and I can overhear their conversation, which was supposed to be a private doctor-patient consultation. One of the women, around her fifties, is accompanied by her daughter, who seems to be in her twenties, and they are discussing with the doctor. The doctor asks the woman, "Are you planning to have a child at this age? I guess not." The woman replies, "I'm not thinking of having a child." The doctor then says, "In that case, let's just remove your uterus." There's a moment of silence, and the woman looks down helplessly. Her daughter interjects, "We're considering this as a last resort. We don't want to opt for surgery if other options are available." The doctor responds, "If it's of no use, why go through the trouble? It's a simple surgery; let's just remove it." Being forced to listen to this conversation made me feel extremely uncomfortable. This was a deeply private matter being discussed, and yet, I was expected to have my own consultation while overhearing this very personal exchange.[171] (From my field notes)

This brief observation, from my fieldwork diary notes, actually tells us a lot of things. Firstly, there was no attention paid to the privacy of the conversation between the doctor and the patient. Both I and the other female patient in the room witnessed this conversation. This was as disturbing for me as it must have been for the woman

[171] Hastanenin koridorunda sıramın gelmesini bekliyorum. Burası özel bir hastane ve Ankara'nın en iyi olduğu söylenen kadın doğum uzmanlarından birisi ile birazdan görüşmem var. randevu sıramı beklerken biraz gerginim, çünkü 5 aydır regl olmuyorum. her ay kan tahlili ve hormon tahlili yaptırmak için hastaneye gidiyorum. başka hastanelere de gittim. aslında son 3-4 sene boyunca hem devlet hastanesi hem de özel hastanelerde farklı jinekologlara göründüm. Bir arkadaşımın tavsiyesi üzerine şimdi de bu özel hastaneye geldim çünkü diğer hastanelerde bir çözüm önerisi alamamıştım. doğum kontrol ilacı kullanmak, yani yapay hormon desteği almak haricinde bana önerilen şey ileride evlenince bu durumun geçeceği idi. Kafamda bu konular beklemeye devam ediyorum. … Nihayet randevu saatim geldi ve içeri girdim. bir özel hastanede olmamıza rağmen randevu için içeriye alınan 3 hastaydım. benim yanımda iki başka kadın doktorun yardımcısıyla görüşme halindeydi ve ben onların konuşmalarına tanık oluyordum. Özel mahrem olması beklenen bir doktor-hasta görüşmesine tanık oluyordum! … Yanımdaki kadın 50 küsür yaşlarındaydı yanında da 20 küsür yaşındaki kızı ile beraber doktorla görüşüyorlardı. Doktor kadına sordu tekrar "Bu yaştan sonra çocuk doğuracak mısın herhalde doğurmazsın" ve kadın cevapladı "çocuk doğurmayı düşünmüyorum". doktor "o zaman rahmini alalım gitsin" dedi. bunun üzerine bir sessizlik oldu. kadın çaresizce başını öne eğdi, kadının kızı "biz bunu en son çare olarak düşünmek istiyoruz. başka şeyler yapılabilirse ameliyat olmak istemiyoruz" dedi. doktorsa "hiçbir işe yaramayacaksa niye sıkıntı yapsın. kolay bir ameliyat. alalım gitsin." Dedi. Orada bu konuşmayı dinlemek zorunda kaldığım için büyük bir rahatsızlık içerisindeydim. çünkü mahrem bir konu konuşuluyordu. Beni o odada bekleterek (doktorumun gelmesini) bu konuşmaya tanık haline getirmişlerdi. Saha notlarımdan.

patient having the conversation. On the other hand, the content of the conversation, specifically the way the hysterectomy was presented to the female patient, is a very important indicator. The doctor asked only one question to her: “Do you want to have children?” and then said, “I suppose you won’t want to have children at this age.” Here, there is an issue related to the woman’s age and fertility. Then the doctor’s reaction is a very mechanical perspective, and at the same time, it is an approach that does not accept the woman having authority over her own bodily integrity and legitimizes the doctor's intervention. In the rest of the conversation, no medical necessity for the hysterectomy was mentioned. The reasons the doctor gave for the hysterectomy were: 1) “Since you won't have children at this age, you don't need a uterus,” and 2) “This is an easy surgery, let's just do it.” This conversation was not beneficial for the patient’s bodily integrity and health. On the other hand, my witnessing this conversation, along with the other female patient, must have had a significant impact on the patient’s mental state.

In our interview with Gönül, she made a very clear distinction between doctors and alternative therapists. She said,

> Doctors have become so mechanical; they do two tests and send you on your way as if you're a robot, not a human being. For instance, I had CIN 2, and the doctor came and said, ‘You have CIN 2 and this other thing; let's remove your uterus.’ Later, four different doctors told me to have my uterus removed. The ease with which the removal of the uterus is discussed, the way the uterine area is seen as unnecessary if one is not going to have children, is another issue.[172] Gönül

The biomedical body, as portrayed in modern biomedicine, is distinctly characterized as machine-like, described in terms of its functionality, systemic nature, structural integrity, physicality, material composition, and mechanical attributes (Moreno Leguizamon, 2005, p. 3304). Here, we see the biomedical perspective treating the body like a machine as in the sense of the biomedical body is constructed as

[172] Doktorlar o kadar mekanikleşti ki; iki test yapıp sizi bir robotmuşsunuz gibi, insan değilmişsiniz gibi yolluyorlar. Örneğin, bende CIN 2 vardı ve doktor gelip, 'CIN 2 ve şu var; hadi rahminizi alalım' dedi. Daha sonra dört farklı doktor rahmimi aldırmamı söyledi. Rahmin alınmasının ne kadar kolay tartışıldığı, çocuk sahibi olunmayacaksa rahim bölgesinin gereksiz olarak görülmesi başka bir konu. Gönül

‘machine’ (Moreno Leguizamon, 2005). According to Gönül’s doctor’s assumption, any part of the body not deemed useful can easily be removed. Remembering the new materialists view that matter is never just a brute, dead substance waiting to be manipulated by human agency, but is instead lively, ever- shifting, and full of potential (Bennett, Barad, Braidotti, and DeLanda).

Secondly, these two cases may provide us a terrain for discussion how the communication between doctor and patient is mechanical. The doctor’s dictatorial, controlling attitude towards the removal of an organ does not consider the patient’s potential emotional state. Additionally, the lack of a sufficient medical explanation—whether there are alternative solutions, what the possibilities are, what the options are, and the expected outcomes of each—highlights the problem. Instead of discussing these topics, which fall directly within the doctor's field of expertise, the doctor provides non-scientific explanations filled with personal opinions and moral and ethical judgments, such as, “You won’t need it since you’re not going to have children anyway,” making the recommendation for surgery very controversial. A similar issue arises in Nüzhet’s experience. During her consultation for endometriosis, the doctor’s recommendation for surgery were based more on personal opinions than on sharing scientific medical knowledge. This was problematic for Nüzhet and led to a breakdown in communication with doctors, causing her to discontinue biomedical treatment methods.

4.3. The Changing Opinions of Women Regarding Their Approach to Health and Illness

Many people use TCAM due to its alignment with their personal health principles and beliefs (Köse et al., 2018). Almost all of my interlocutors acknowledge the significance they attribute to the doctor-patient interactions. They want to be heard, listened and they want to ask questions about their unique experiences and expect some explanations from the doctors whether it be about a prescribed medication or about life style or the reasons of the chosen treatment method.

Patients turn to alternative therapies because TCAM practitioners are seen as less authoritarian (Reismann, 1994) and offering more personal autonomy (McGuire,

1988; Riesmann, 1994; Duggan, 1995; Kleinman, 1984; Vincent & Furnham, 1996). Women, in particular, seek control over their healthcare and treatment decisions. Studies show that women using TCAM report greater autonomy and control compared to those relying on conventional treatments (Sarada et al., 2021; James et al., 2018). Similarly, the experiences of my interlocutors reflect a desire for more personal autonomy in managing their health.

In my fieldwork, all the interlocutors were highly educated, holding at least a bachelor's degree, with many having completed M.A., M.S., or PhD. programs. This level of education is closely tied to their desire for more information about their health. They generally asked detailed questions during consultations and expressed a need for clear explanations regarding their treatments. For example, Nüzhet, a mechanical engineer with an analytical mindset, grew frustrated when her doctor responded to her questions with personal moral opinions rather than scientific answers. This pivotal moment led her to explore alternative methods. Many of the women, like Nüzhet, felt empowered to take more responsibility in their treatment decisions, both because of the participatory nature of TCAM and the practitioners' approach.

The interlocutors tells about the modifications made to their dietary regimen, detailing the detoxification process they underwent for the liver and internal organs through the implementation of an elimination diet.[173] Describing the outcome as a "miracle," Safiye highlights the remarkable results observed in a time frame of merely three months.

> Safiye: I cut out five things. She convinced me. The first month, it didn't work at all. I didn't feel anything. I continued. I didn't feel anything for two months either. In the third month, I had the first and most painless period of my life, and it felt like a miracle. It lasted for three months.
> I: How did you decide?

[173] I will deal with the detoxification issue in the following section making its relation with the healing process. As described in Sherianna Boyle's book Emotional Detox: 7 Steps to Release Toxicity and Energize Joy,emotional toxins, things the body has been carrying for too long, are needed to be released. Boyle (2019) explains that emotional detoxing is just as important as physical detox. Her C.L.E.A.N.S.E method guides people through a process of clearing negative emotions and finding acceptance and joy.

> Safiye: I got excited and decided. I said, okay, starting tomorrow, I am cutting out these five things (lactose, gluten, sugar, meat, packaged food). By the way, within a week, there was something. I was seeing a doctor. I think there were finals that week. There were finals. A few days before the finals, I made the decision. And I remember the next day, when I woke up and opened the fridge, I couldn't find anything to eat. Because I had eliminated everything. I remember panicking, wondering what I was going to eat. I went to the market, for example, and only bought vegetables and fruits. I didn't buy packaged food. I don't remember the details now. My main concern was additives. Alcohol, drugs, yeast, additives, and meat. Meat was written like this: eating a lot of meat also burdens the liver. Years later, I realized that the main reason was the hormones and drugs in the meat. It's not about the protein load, but rather the hormones and drug load in the meat, I think.[174]

Having recognized the numerous advantages of implementing alternative methods, the respondents observed significant improvements and opted to consistently use these techniques. One of the significant results of the fieldwork is that most of the TCAM methods have been used by women upon on their self-prescription.[175]

Pakize's tendency towards TCAM methods has started with her pregnancy journey. Before that she was not interested in traditional and alternative medicine. Her story:

> Well, until I got pregnant, I actually didn't have any knowledge about these things. I was neither aware nor interested in them. How did that process start? It's very interesting. I can really say that after I got pregnant, my hormones directed me a lot. My instincts and desires led me quite instinctively. I attended prenatal yoga classes while I was in Istanbul, and the instructor there was very sweet.

[174] o 5 şeyi kestim. beni ikna etti. ilk ay hiç işe yaramadı. hiç bir şey hissetmedim. devam ettim. 2 ay da bir şey hissetmedim. 3. ay hayatımın ilk ve en ağrısız süper reglisini yaşadım ve mucize gibi gelmişti. 3 ay sürdü.Safiye
Ben: nasıl karar vermiştin?
böyle gaza gelip karar verdim. tamam dedim yarından itibaren bu 5 şeyi kesiyorum (laktoz, gluten, şeker, et, paketli gıda,). bu arada 1 hafta içinde de bir şey vardı. doktora yapıyordum. finaller vardı galiba o hafta. finaller vardı. finaller başlamadan bir kaç gün önce karar verdim. ve böyle ertesi gün şeyi hatırlıyorum. uyandığımda buzdolabını açıp yiyecek bir şey bulamamıştım. çünkü herşeyi eledim. ne yiyeceğim ben diye panikle kaldığımı hatırlıyorum. gittim markete mesela, sadece sebze meyve aldım. ambalajlı gıda almıyorum. şu an detayı hatırlamıyorum. asıl derdim katkı maddesi idi. alkol, ilaç, maya, işte katkı maddesi ve et. et de şöyle yazıyordu. çok et yemek de karaciğere yüklenir, yazıyordu. seneler sonra anladım ki asıl sebep etin içindeki hormonlar ve ilaçlar asıl olarak. protein yüklemesi değil asıl konu. etin içindeki hormonlardan ve ilaç yüklemesi dolayı sanırım. Safiye

[175] Bowe et al.'s (2015) research on women with breast cancer highlights that self-prescribed CAM use remains an under-explored area.

The process of bonding with the child, chatting with the mothers their week by week, listening to the experiences of the mothers there, like, “Which week are you in now? What are you experiencing?” You evolve a bit from that. Then I also attended a childbirth education class. The same yoga instructor had a childbirth education class. It was at Inanna Women and Health Awareness Center. You might have heard of Şaylan. I attended her course and learned a lot of things there for the first time. How does labor start? Like, after that, what happens? Oxytocin affects your uterus in this way. When the baby starts coming, it begins to pass through the canal in this way. It was quite technical but also showed how natural the process is, right? I think I was very impressed by that. And I also read Ina May’s book. And I also read the “Birthing From Within” book.

... Natural birth stories. Stories of what everyone experienced. Maybe 30 different stories, and I realized that this is a very organic and natural thing. Someone else’s experience might be different, but what do I want? And I definitely decided that I wanted to give birth to my child naturally, in my own way. Thanks to yoga, I also learned the poses, massages, etc., to be done during childbirth. They were very helpful. Then I gave birth in America. My husband had a connection in America at that time. He had lived there a bit years ago. We decided to go to the city he knew. I researched for 18 hours for a doctor who supports natural birth. Could I have found one in Türkiye? I don’t know.

Then I found one, and he was incredibly relaxed. He didn't do medical checks, just examined me by touching my belly. He didn't do a pelvic examination, never irritated me during the exams. He was very sincere, like, "How are you? How do you feel? Okay, everything is fine.[176] Pakize

[176] Şöyle, yani hamile kalana kadar aslında hiç bunlarla ilgili bir bilgi sahibi değildim. O süreç nasıl başladı? Çok enteresan. Gerçekten çocuğa hamile kaldıktan sonra hormonlarımın beni çok yönlendirdiğini söyleyebilirim. Yani o iç güdüsel olarak şeylerim isteklerim beni çok yönlendirdi. Hamile yogasına gittim Istanbul’dayken ve hani oradaki eğitmen de çok tatlıydı.
Oradaki şeyle çocukla işte bağ kurmak, oradaki annelerle sohbetler işte hafta hafta. Hani oradaki annelerin süreçlerini duymak işte şimdi kaçıncı haftasın ne yaşıyorsun? Filan orada birazcık zaten evriliyorsun. Sonra da işte şeye gitmiştim. Böyle bir bebek- doğum eğitimine. aynı yoga eğitmeninin. işte bir doğum eğitimine gitmiştim. …Inanna Kadın ve Sağlık Farkındalık merkezi. Şaylan’ı duymuşsundur. Onun eğitimine katıldım ve orada ilk zaten hani bir sürü şeyi öğrendim. Doğum nasıl başlar? işte hani o olduktan sonra şu olur, işte oksitosin işte, rahmine şu şekilde etkiler, işte bebek gelmeye başladığında hani şu şekilde kanaldan geçmeye başlar. Bayağı teknik tarafta ama bir taraftan da hani süreci nasıl doğal akışta olduğunu gösteren bir şey değil mi? Ben hani oradan sanırım çok bir şey oldum, etkilendim. Bir de Ina May’in kitabını okudum. Bir de İçsel Doğum kitabını okudm.
…doğal doğum hikayeleri. Herkesin başından geçen hikayeler. Belki 30 tane ayrı ayrı hikaye ve hani orada da şey farkına vardım. Yani bu çok organik ve doğal bir şey. Birisinin yaşadığı tecrübe başka olabilir ama ben nasıl istiyorum? Ve ben kesinlikle kendim çocuğumu kendi akışında doğurmak istediğime karar verdim. Işte o yoga sayesinde de orada. Hani o doğum sırasında yapılacak pozlar, masajlar vesaire onları öğrendim. Onların çok katkısı oldu. Sonra da ben bu arada Amerika’da doğum yaptım. Eşimin o ara Amerika'da bir bağlantısı vardı. Yıllar önce biraz orada yaşamış. Onun bildiği işte yaşadığı şehri gitmeye karar verdik. 18 saat boyunca doğal doğum yaptıran bir doktor araştırdım. Belki Türkiye'de bulabilir miydim bilmiyorum.
Sonra onu buldum ve gerçekten adam çok inanılmaz rahat bir tipti. Yani böyle medikal kontrolleri hiç yapmayan, sadece böyle hani karnıma dokunarak muayene eden. işte çatı muayenesi yapmayan. beni

In the narrative, we see a transformation in her approach to health and wellness, which ultimately led her to embrace holistic medical therapies. Pakize's account reflects a personal journey that challenges the biomedical model, which is critiqued for its mechanistic, interventionist, and impersonal approach to childbirth. Her story emphasizes an instinctual, holistic experience shaped by her body's natural rhythms and supported by a community of women, alternative knowledge, and practices such as yoga and childbirth education.

In Pakize's story we can trace a broader critique of biomedicine's disconnection from the emotional and social dimensions of women's health. Her narrative exemplifies a critique of biomedical hegemony in reproductive health. As I discussed in 1.5 and 3.2. biomedicine approaches childbirth in a highly medicalized way, emphasizing control, surveillance, and intervention. Her account can conceptualized through feminist critiques of medicalization, where women's bodily autonomy and experiential knowledge are marginalized in favor of expert-driven, medicalized protocols. In contrast, Pakize's experience shows an alternative, holistic approach that integrates both physical and emotional dimensions of childbirth. She describes a process guided by instinct and a focus on natural, less invasive techniques, which speaks to a resistance against the medicalization of childbirth. Pakize's interest began with prenatal yoga classes, where the instructor's supportive and nurturing environment helped her bond with her baby and connect with other expectant mothers. This sense of community and shared experiences played a crucial role in opening her eyes to alternative practices. Her reference to techniques such as yoga, as well as the emphasis on oxytocin and natural labor progression, highlights a reliance on alternative health practices that prioritize the body's self-regulation and emotional well-being.It also connects to the concept of embodiment, emphasizing how bodily knowledge and natural processes can be reclaimed and understood through a woman-centered, less interventionist lens (Sullivan, 2001).

Additionally, her desire for a doctor who avoids intrusive medical checks and her preference for learning through storytelling and shared experiences in women's

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böyle hiç amex boyunca irrite etmeyen. Hani nasılsın, nasıl hissediyorsun? Tamam her şey yolunda falan diyen bir adamdı. Çok samimi. Pakize

circles demonstrate the importance of social and emotional support in childbirth. These experiences reflect the social aspects of holistic health practices, where childbirth is seen not only as a medical event but as an intimate, communal, and emotional process. Additionally, women value traits such as approachability, empathy in TCAM practitioners, which influences their decision to seek alternative treatments. This perspective emphasize the significance of cultivating relationships with oneself, others, and the natural world. Holistic practitioners frequently draw upon ancient healing traditions, such as Traditional Chinese Medicine, Ayurveda. Their approach to women, as in the case of Pakize's doctor, encourages self-awareness, self-care, and the cultivation of a healthy lifestyle that supports the well-being of the person (Guttmacher, 1979).

The influence of familial and cultural factors on the tendency to CAM has been extensively documented in prior research (Ashraf et al., 2019; Yurtseven et al., 2015; Lee et al., 2004). Consistent with these findings, my fieldwork indicated that women get information from their environment such as from their family members, work colleagues, acquaintances, and mass media. Pakize's knowledge has increased with her friends and yoga circle. Attending a childbirth education class further deepened her understanding and appreciation for natural birth processes. Here, she learned about the physiological and psychological aspects of childbirth, which demystified the process and empowered her with knowledge.

> I: Did you have any other sources? The one who supports you in such matters, that is, throughout the pregnancy.
>
> Pakize: So, I can say that the books I actually read. I have read a lot, I gave a few examples: gebology, internal birth, etc. You know, the books were very useful. I also joined groups. On Facebook, it was called baby care, human care, baby repair, I don't know, it was something like that. I left later. For example, I found it very useful. They share birth stories there too. Actually, I think the stories of other women are more inspiring. Somehow they came across like this, or I guess I accepted them as normal. This may also be difficult. But that is why this is such a unique thing. They were very useful to me. Other women, my pregnant friends, my friends who have just given birth, I have had a lot from them.[177]

[177] Ben: Başka kaynakların var mıydı? Sana bu tür konularda destek olan yani o hamilelik sürecinde gebelik boyunca.

These online groups provide her to connect with other women who share their experiences and insights. These online communities offered Pakize information and emotional support. Her reliance on books, online groups, and the shared experiences of other women highlights a shift away from purely medical authority toward a **community-based** and **holistic approach** to navigating pregnancy.

She makes a comparison between her early pregnancy period in Türkiye with her medical doctor and her holistic doctor in US in terms of their approach to women body and the use of medical monitoring:

> So, while I was in Türkiye, I went into the medical check-ups section a little bit, but my doctor was not a doctor either, he was a doctor who said, "I do not believe this is necessary." That is why I was going to the river.
>
> So for example. At work. Down syndrome testing is done. For example, there are such varieties of it. For example, it can be looked at in this detail, I don't know where I can get this done, down to this detail, it can also cause other diseases, etc. He made them feel more flexible like this. They do a sugar test and you are loaded with glucose. Something you wouldn't do if you wanted to. We had it done in one of them. He said, "It wasn't at the first stage, but as if something happened at a later stage. If you want, let's get it done this time." Because you drink such glucose there. In fact, it is not something that is very beneficial to the child. You drink sugar. But of course, checking the child's heartbeat is definitely related to the child's health. But it was different when you went to America, for example. The people here (TR) are always putting you in their ultra. How many centimeters is it? He was examining it, touching it, squeezing it, looking at it.[178] Pakize

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Pakize: Yani aslında okuduğum kitaplar diyebilirim. Epey okudum hani bir kaç tanesine örnek verdim: geboloji, içsel doğum falan böyle. Hani kitaplar çok faydalı oldu. Bir de gruplara girmiştim. Facebook'ta bebek bakım onarım, beşer bakım, bebek onarım mı bilmiyorum öyle bir şeydi adı. sonradan çıktım. O mesela, çok faydasını gördüm. Orada da doğum hikayeleri paylaşıyorlar. Ya aslında diğer kadınların bence hikayeleri daha ilham verici. Bir şekilde benim karşıma böyle çıktı veya ben onları da normal kabul ettim herhalde. Ya zorluğu da olabilir bunun. Fakat bu böyle çok kendine has bir şey o yüzden. Onlar bana çok faydalı oldu. Diğer kadınlar, hamile arkadaşlarım, yeni doğum yapan arkadaşlarım onlardan çok şeyim oldu.

[178] Yani şöyle bir şekilde Türkiye'deyken olan kısmında medikal kontroller kısmına biraz girdim, ama benim doktorum da şey bir doktor değildi, bunun çok şart olduğuna inanmıyorum diyen bir doktordu. irmağa da o yüzden gidiyordum. Yani mesela. Işte. Down sendromu testi yapılıyor. Orada mesela işte onun böyle çeşitleri var. şu detayda bakılabilir işte, bunu bilmem nerede yaptırırsam bu detaya kadar, işte başka hastalıkları da çıkarabilir falan gibi şeyler mesela. O onlarda böyle daha esnek bıraktırıyordu. şeker testi yaptırıyorlar işte sana glikoz yüklemesi yapılıyor. istersen yapmayacağın bir şey. Bir tanesinde yaptırdık, Ilk aşamada değil de sanki ilerleyen bir aşamada bir şey oldu da istersen yaptıralım bu sefer dedi. Çünkü orada böyle bir glikoz içiyorsun. Aslında çocuğa da çok faydalı olan bir şey değil. Şeker içiyorsun. ama tabii ki çocuğun kalp atışına bakıldığı hani illa ki çocuğun sağlığı ile ilgili. ama örneğin Amerika'ya gidildiğinde farklıydı. buradakiler (TR) devamlı seni ultrasına

It can be articulated that Pakize's decision to give birth naturally reflects a broader resistance to the medicalisation of childbirth, a process in which cultural meanings of birth have been subsumed by medical events. According to Pehlivanli and Gedik (2024), women in Türkiye navigate complex cultural and political discourses about pregnancy and childbirth. These discourses have led to the professionalization of birth, where normal biological events are increasingly treated as pathological conditions requiring medical intervention.[179] Previous studies (e.g., Prosen & Krajnc, 2019; Rúdólfsdóttir, 2000) have noted that medicalisation has resulted in the increased use of medical interventions, such as fetal monitoring and birth surgeries during pregnancy. This medicalisation disempowers pregnant women,[180] transforming them into "living fetal monitors" (Mitchell, 2001, p. 97), which Pakize did not want for her pregnancy process.

The most visible difference between traditional medicine and modern medicine is with regards to how they set their knowledge. Modern medicine is based on accurate scientific, experimental information in a cause-and-effect model and causality. TM is formed by a team of experiences and faith rather than the logical link as expected by the modern scientific rationale. However, this does not mean that the beliefs and practices of TM are arbitrary. It is completely structured within itself (Özçelik, 2015, p. 65-67). As in Pakize's pregnancy process and how she had natural birth, we can see this structure. She used natural products, physical exercises, specific yoga poses and relaxation methods, herbal teas[181] which are stemming from some structured knowledge settings such as Ayurveda, yoga or Traditional Chineese Medicine.

In summary, her shift towards holistic medical therapies and natural healing was gradually increased. It was driven by her pregnancy, supported by educational

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sokuyorlar. Kaç santim oldu, su seviyen ne kadar, çocuğun kafası şu kadar büyümüş, işte efendim boyutu şöyle olmuş, sen şu kadar almışsın, Mesela ben orada işte o kadar o detaylı taramalara girmedim. Dediğim gibi karnımdan hani? Muayene ediyordu, böyle elliyordu, sıkıştırıyordu, bakıyordu. Pakize

179 In the Chapter One: Introduction of this thesis medicalisation has been discussed in detail.

[180] Medicalisation of pregnancy compels women to adopt biomedical forms of birth (Pehlivanli & Gedik, 2024).

[181] A substantial body of research from both Asian and Western countries has shown that women are significantly more likely to use herbal medicines compared to men (Yi et al., 2017; Peltzer et al., 2016; Harris et al., 2012; Han et al., 2015).

experiences, and reinforced by positive, respectful medical care. This holistic philosophy aligns with her newfound belief in the natural, instinctive processes of the body, emphasizing the importance of supportive, non-invasive, and empowering healthcare practices

The data obtained from the interviews indicates that the average time period in which women have been seeking their treatment for reproductive health issues was more than 5 years; some cases were around 15 years of seeking solutions to the recurring problems.

Tangkiatkumjai et al. (2020) conducted a systematic literature review using a keyword search strategy on Pubmed, ScienceDirect, and EMBASE to identify articles published in English between 2003 and 2018. Keywords included 'herbal medicine' or 'herbal and dietary supplement' or 'complementary and alternative medicine' combined with 'reason' or 'attitude'. According to their extensive research, the reviews highlighted several primary motivations for using CAM. These include anticipated benefits and perceived safety of CAM, the desire for greater control and involvement in an individual's treatment, and alignment with sociocultural beliefs and personal needs (Tangkiatkumjai et al., 2020; see for example; Weeks et al., 2014; Verhoef et al., 2005; Reid et al., 2016; Frenzel et al., 2013). Another group of studies identified various reasons for CAM utilization: the benefits and safety associated with CAM, its availability and accessibility, influence from social networks and media, and dissatisfaction with conventional medicine (Tangkiatkumjai et al., 2020; see for example; Truant et al., 2013; Bishop et al., 2007; James at al., 2018; Qureshi et al., 2018; Yang et al., 2017; Jakes et al., 2014).

This chapter delves into the reasons behind the multifaceted factors driving dissatisfaction with conventional biomedicine. The most prevailing reasons are the ineffectiveness of biomedical treatments, the presence of adverse effects, the perceived impersonal nature of biomedicine, and the sexist aspects of biomedical care and practitioners.

This chapter until now delves into the reasons behind the multifaceted factors driving dissatisfaction with conventional biomedicine. The most prevailing reasons are the

ineffectiveness of biomedical treatments, the presence of adverse effects, the perceived impersonal nature of biomedicine, and the sexist aspects of biomedical care and practitioners.

4.4. Embodied Healing and Women's Circles: Cultivating New Ways of Relating

In May 2021, I was about to travel out of the city for the first time since the pandemic began. I had been participating in the *Mystical Femininity Instructor Training*[182] *(Gizemli Dişilik Eğitmenlik Eğitimi)*, which had been held online for the past six months due to the pandemic. The final part of the training would take place as a five-day residential retreat, and during this retreat, we would graduate as instructors by moderating women's circles. Each of us was expected to organize a circle, using the techniques we had learned and adding our personal style to the experience. I had prepared myself, both mentally and physically, to lead a group of 15 to 20 women and to hold the space for the circle.

As part of my preparation, I bought a cream-colored circular cloth, candles, natural stones, and small jars of homemade hand cream to give as gifts to the participants. While I had everything ready, I couldn't shake the sense of heaviness I felt inside. Was I anxious about what might happen at the retreat? I was hesitant, and the trip felt like a huge challenge. Was I truly ready for this experience? For months, I had been practicing daily body exercises, yoga, dance, breath work, detoxes, and following a hormone-balancing diet. I also kept an 'Inner Journey Journal' (İçsel Yolculuk Günlüğü) where I recorded my emotions and tracked the connection I was building with my body and myself. But honestly, the process had not been as simple or enjoyable as it might seem. As I finished packing the rest of my suitcase, these thoughts were on my mind. I packed my aromatic oils, the red and white dresses

[182] The announcement on the website begins as follows: "Are you ready to be part of the global women's healing movement in these transformative times? No matter what stage of life you're in, what environment you're surrounded by, or what work you're involved in, if you want to be part of change and have the vision to actively contribute to it, this comprehensive program is for you. Let's explore together the inner structures that form the foundations of creation and development, from the moment we arrive in the womb to the journey through menopause". See: https://www.gizemlidisilik.com/online-gizemli-disilik-egitmenlik-prog-155-saat/

requested for the circle, and essentials like sheets, pillowcases, and my own dishes, since we were required to bring them. The retreat was set in a small mountain village, in a simple farmhouse turned into a stone house, with wooden bungalows and a few tents. I had been there six or seven times before for yoga training, so the place was familiar to me. My unease was not about going to a new location.

What worried me was the emotional work I knew I would have to face. The months of practice had already stirred up deep feelings within me, and the idea of confronting them again in a group setting felt overwhelming.[183] Sometimes after bodily exercises, uncomfortable emotions would surface. During detoxes, it wasn't just physical toxins being released. As described in Sherianna Boyle's book *Emotional Detox: 7 Steps to Release Toxicity and Energize Joy,* emotional toxins, which are the things the body has been carrying for too long, were also being released. Boyle (2019) explains that emotional detoxing is just as important as physical detox. Her C.L.E.A.N.S.E method guides people through a process of clearing negative emotions and as a result of it people come to finding acceptance and joy.[184] When going through a detox, it is common to experience emotional releases as the body and mind cleanse. These emotional reactions can include sadness, anger, or frustration, which are often suppressed emotions resurfacing. Instead of fighting these feelings, it is recommended to acknowledge and process

[183] Focusing on my embodied experiences as a woman and feminist, I emphasized the importance of incorporating the researcher's emotions and experiences into fieldwork. In the methodology chapter, I addressed this through the participant-researcher interaction. During interviews, I created a safe space for women to share their stories of illness and treatment, which often brought out strong emotions. Some participants cried or had shaking voices as they recounted their struggles. These emotionally intense moments required both a balanced nervous system and academic skills. Additionally, my own embodied experiences played a crucial role in this research. Having personally engaged in these practices, I experienced firsthand the processes, challenges, and reliefs involved in my own healing journey. As I navigated these embodied experiences, I continued to assess them from a researcher's perspective. During the writing process, I often reflected on times before starting this dissertation when I felt isolated in my pain, unable to find solutions, which was emotionally distressing. Feminist methodology, supported by academic research and ethnographic studies, provided me with valuable tools to make sense of my experiences and connect my personal journey with broader research insights.

[184] Bonnie Coberly also emphasizes the importance of emotional acceptance during detoxing. As the body undergoes cleansing, emotional reactions can emerge. Demetra Szatkowski from *Mind Body Green* advises, "When emotions like tears or frustration arise, it is important not to suppress them, but rather acknowledge and accept what is happening. The purpose of this release is to let go of deeply buried negativity." She emphasizes that by allowing yourself to process these emotions, rather than suppressing them, you'll ultimately feel much better.For details see: https://www.mindbodygreen.com/

them. Allowing oneself to cry or express anger helps release negativity, rather than re-burying it (Boyle, 2019). My experiences were in alignment with these processes and I can say they led me to confrontations with myself, family, and friends, bringing up old memories and triggering deep reflection. As far as I observed many other women have gone through similar experiences with their environment too.

The emotional release experienced during detoxification aligns with the work of Gabor Maté, who emphasizes the deep connection between emotional well-being and physical health. At this point, I want to highlight Mate's insights on how emotions and stress are stored in the body and their link to illness. In his book *When the Body Says No*, Mate (2019) explains that emotional repression and unresolved trauma can manifest as physical symptoms and disease. This aligns with the emotional releases seen during detox processes, where emotions such as sadness, anger, or fear are stirred up as the body undergoes cleansing. Drawing on Mate's concept of 'toxic stress', similar to physical toxins, these unresolved emotions need to be processed rather than suppressed.

When detoxing physically, people often experience emotional detox as well, which Mate would argue is a sign of the body starting to heal from long-held emotional wounds. Similarly, the book *The Body Never Lies* by Alice Miller focuses on the psychological impacts of childhood trauma and emotional repression. Miller's work is about how unresolved emotional issues, especially those stemming from childhood, manifest later in life, particularly through psychological and even physical symptoms like illness (Miller, 2006).

By integrating Miller's and Mate's ideas, I argue that the emotional releases during a juice detox and bodily detoxifying practices are not just incidental but are essential for healing. Processing these emotions, as Mate advocates, is crucial for both emotional and physical well-being. This connection between the emotional release and the healing also enhances my argument that women's reproductive health needs to be evaluated under a biopsyhosocial framework (Engel, 1977) since the phenomenon of emotional detox is a vital part of healing. This connection also emphasizes how mental and emotional health is deeply intertwined with physical health.

The emotional release practice is also mentioned by the interlocutors. For instance, Gönül (age 50), tells about her joining in a Transformational Breath® Camp[185] for 5 days:

> This happens in hotels, under the name of transformer breath. Kravitz[186] comes from America. After that, there are teachers. It's a big organization, so 30-40 people come and other than that, coaches help. Each person has a one-on-one coach. So it is such an organization. Here life is breath. There are methods that allow you to breathe through your mouth. Blah blah blah, you see crying spells. So don't punch a pillow to take out your anger. That is how you start to tone down angry things. During the sessions, old memories come up, things you cannot express. This throat problem was tiring me the most. Because I have problems with not being able to make a sound. You become a little lighter each time. Then there was also the practice of forgiveness. In that forgiveness work, he brings someone to him and says, "Tell me a secret you have never told me." There I told about the rape incident, which I had never told anyone, and there was a wonderful catharsis. So there was a big cry and anger. and support with breath. They don't leave you like that. By saying stay in the breath, return to your breath, return to the moment, it transforms, it transforms with the breath. You don't stay in that crisis; your breath is like a broom picking up all the dust. It is very interesting that it seems like it's sweeping away your anger, your anger, your sad crying. After that, I decided to become a breathing coach.[187] Gönül

[185] Transformational Breath® is a powerful self-healing technique that facilitates significant personal change through a specialized breathing pattern. By harnessing high vibrational energy, this method enhances breathing, boosts energy, fosters peace and love, and helps individuals achieve higher states of consciousness (Kravitz, 2022). See the official web page: https://www.transformationalbreath.com/blog/what-is-transformational-breath

[186] Dr. Judith Kravitz, a pioneer in breath work, developed Transformational Breath® in 1977, a technique that has since helped millions worldwide. A recognized leader in metaphysics and spirituality, she also created the Metaphysical Manifestation Program, guiding individuals to achieve their dreams. With over 35 years of experience, Judith has led programs globally, focusing on breath work, women's empowerment, and personal transformation. Her work combines love, skill, and intuition, helping people find their voice, reclaim their power, and manifest their desires.

[187] Bu otellerde oluyor, transformer nefes adı altında. Kravitz Amerika'dan geliyor işte. Ondan sonra hocalar var. Büyük bir organizasyon yani 30 40 kişi geliyor ve onun dışında koçlar yardımcı oluyor. Her kişinin birebir koçu oluyor. Yani o öyle bir organizasyon. Işte hayat nefestir. işte ağızdan nefes aldırıp, vermeil yöntemler var. falan falan ha bir bakıyorsun ağlama krizleri. işte öfkeni çıkartmak için yastık falan yumruklama. öfkeli şeyleri böyle bir hafifletmeye başlıyorsun. Seanslarda eski anılar geliyor işte ifade edemediklerin. beni en çok bu boğaz kousu yoruyordu. işte ses çıkartamama sorunlarım olduğu için. her seferinde biraz daha bir hafifliyorsun. Sonra hatta bir şeyde de affetme çalışması vardı. O affetme çalışmasında da karşısına birisini getiriyor, diyor ki sana "hiç söylemedigin bir sırrını anlat" diyor. orada zaten ben hiç kimseye anlatmadığım tecavüz olayını anlattım ve orada acayip bir katarsis oldu. Yani büyük bir ağlama ve işte öfke çıktı. ve nefesle destek.seni öyle bırakmıyorlar. Nefeste kal, nefesine dön, ana dön diyerek sen o dönüşüyor, nefesle dönüşüyor. O krizin içinde kalmıyorsun, nefes sanki bir süpürge bütün tozlarını alıyor. Oradaki senin o kızgınlığını öfkeni, o üzüntülü ağlamanı böyle süpürüyor gibi bir şey çok enteresan. Ondan sonra ben zaten nefes koçu olmaya karar verdim. Gönül

Gönül's experience with the breath work sessions was transformative for her. The process allowed her to access and release deep-seated emotions and old memories, leading to a significant emotional catharsis. The structured guidance through breathing exercises provided a means to navigate her intense emotions. The session she describes leads to facilitate emotional catharsis and healing through breathing. As Miller's (2006) and Mate's (2019) insights offer the practice helps her process and release deep-seated emotions, such as anger and grief, related to past traumas. The mention of "crying spells" and "anger" indicates that the breathing technique allows her to confront and express suppressed emotions. Moreover, an other form of releasing of emotions happens through the practice of sharing a deep, personal secret (such as the rape incident). She indicates that the forgiveness work is an integral part of the therapeutic process. This method suggests that breathing techniques can facilitate significant emotional breakthroughs and self-forgiveness, which supports healing.

4.4.1. The Role of Embodiment in Healing

As Christiane Northrup (2013) explains in her book *Women's Bodies, Women's Wisdom*, women's organs—especially the ovaries, womb, and breasts—are places where emotions and memories, even those passed down from our mothers and grandmothers, are stored. Healing, she says, comes from connecting with this wisdom.In Eastern medicine like Traditional Chinese Medicine and Ayurveda, the body and the mind aren't regarded as separate at all. Emotional experiences whether joy, grief, anger, or similar feelings, affect the tissues of the body and the functioning of organ systems. The mind and body are closely connected and cannot be considered separately. Emotions are not confined to one specific area, such as the hips, but can be stored throughout the body. Depending on an individual's unique patterns of tension, emotional stress can accumulate in areas like the feet, jaw, shoulders, or hips (Anandi, 2024).

In addition to all the inner, emotional and physical practices during *Gizemli Dişilik Training*, I engaged in exercises and practices known as 'womb wisdom' or 'womb healing,' which provide bodily, mental, and psychological insights. These practices

included meditations, massages, dance, *yoni spa*[188] and the use of *yoni eggs*[189]. While I continued to read and conduct scientific research for my dissertation at a cognitive and knowledge-gathering level, the process in these "mystical femininity" training was entirely experiential. Rather than presenting knowledge about the feminine in a traditional educational format or through books, we were given practical assignments. We were asked to perform these practices, such as a three-day nutritional detox, a one-hour self-administered abdominal and lymph massage, or free-form dance to awaken feminine energy, and then reflect on how these practices made us feel and what they helped us release. Over time, we observed our personal development and tracked our progress over several months. Previously I joined *Kadın Bilgelik & Şifa Sanatı Kampı (Women's Wisdom & Healing Art Camp)*[190] (3

[188] Yoni spa is a vaginal healing method. One of the interlocutors explain her experience very detailed. With Tijen's narration: "The method we call yoni spa is a method that provides relaxation of the vagina, pelvic floor, muscles and veins with the vaginal steam method. This method, how should I say it? By throwing medicinal herbs into boiling water, the steam passes into the vagina. It has a mechanism. It has a stool. Sitting there. It is a method that allows the steam of the medicinal herbs to pass into the vagina. In this method, I honestly did not do much technical mathematical. When I sat down, I was listening to a mantra. I turn off everything. I turn off the TV. I do not read a book or anything. I focus on it. The steam of those medicinal herbs spreads from my vulva to my vagina, my uterus and my ovaries. The dried blood from the previous menstrual period on the uterine wall softens and flows from my uterus, relaxing, those muscles loosening. I was already feeling the healing of that area psychologically like that. I did not do it mechanically. I was establishing a very nice connection. I'm doing something that's good for you".
Turkish originale: yoni spa dediğimiz vajinal buhar yöntemi ile vajinanın rahatlamasını sağlayan , pelvik tabanın, kasların, damarlların rahatlamasını sağlayan bir yöntm. Bu yöntem de yani nasıl diyim. kaynayan su içine şifalı otların atılması ile buharını vajinaya geçisini sağlamak. onun bir makanizması var. taburesi var. orada oturup. şifalı bitkileirn buharının vajinaya geçmesini sağlayan bir yöntem. bu yöntemde de ben açıkçası çok teknik olarak matematiksel yapmadım. oturduğum zaman bir mantra dinliyordum. herşeyi kapatıyorum. tv kapatıyorum. kitap falan okumuyorum. ona odaklanıyorum yani. o şifalı bitkileirn buharı benim vulvamdan vajinama rahmime yumurtalıklarıma yayılıyor. bir önceki aylardaki adetten kalan o rahim duvarındaki işte bir önceki reglden kalmış olan kurumuş olan kanların yumuşayıp rahmimden akması, rahatlaması, o kasların gevşemesi. o alanın şifalandığını direk böyle psikolojik olarak hissediyordum zaten. mekanik yapmadım. gayet güzel bir bağ kuruyordum. sana iyi gelen bir şey yapıyorum diye.

[189] Yoni eggs, also known as jade eggs, refer to semiprecious stones shaped and polished into an egg form to be inserted into the vagina. This practice dates back over 5,000 years, with historical records indicating that empresses and concubines in ancient China utilized jade eggs to harness sexual power, enhance sensuality, and sustain health throughout their lives. Traditionally, this esoteric practice was reserved for royal families and select Taoist practitioners. The term 'yoni' is derived from Sanskrit, denoting the female genitalia as a "sacred space." This concept has been revered in Eastern cultures for its associations with life, creativity, and love. Employing the term "yoni" in Western contexts can foster a greater recognition and respect for the profound creative and transformative power inherent in this aspect of the female anatomy.

[190] This Women's Wisdom & Healing Art Camp offers a comprehensive approach to self-healing through natural methods, focusing on hormonal health, fertility, and overall well-being. It provides practical, effective tools to improve women's health and balance across all areas of life.

days retreat) and Kadın Bilgelik & Şifa Sanatı Sertifika Prog. (*Women's Wisdom & Healing Art Certificate Program)*,[191] 160 Hours Training Programme, these two were also based on practicing and experimenting on oneself. These three training and retreats have so many common themes and alternative healing practices.

The *Gizemli Dişilik Training* involved 20 women, and in 2021, I completed my certification as an instructor. The following year, I volunteered as an assistant for another group of 20 women, witnessing their six-month journey. This training did not claim to be a health camp but promised women the opportunity to connect with their feminine nature and to feel empowered to overcome relational and physical problems in their lives. However, most of the women who attended had reproductive health issues, such as ovarian cysts, endometriosis, uterine problems, uterine cancer, breast cancer, or other health concerns related to female hormones.[192]

The alternative healing practices that are advised to address or balance these reproductive health issues were largely similar across different conditions. For example, from my fieldwork a young woman experiencing amenorrhoea, a woman diagnosed with early menopause, and another woman with thyroid and hormonal imbalances were all encouraged to adopt similar lifestyle changes through these practices. Even though there were variations in dietary recommendations and some medical interventions between women with endometriosis and women with ovarian cysts who experienced long, heavy menstrual bleeding lasting 8–10 days, the core alternative healing practices remained the same under the umbrella term: 'womb healing.' These practices focused on building a relationship with the female body,

[191] The call for program starts with: "We will learn how to heal ourselves naturally, support our families, and show other women how to do the same. We will embrace the traditions of ancient women healers, blend them with modern healing, and reawaken healthy feminine energy over and over again". See https://gulenaypema.com/seminerler/kadin-bilgelik-sifa-sanati-prog-160-saat/

[192] A notable section of the announcement was devoted to women's health issues, and it was clearly stated that a call was made to women who were suffering from this issue: Women's health is one of the most important issues today. Without good health, we lack the energy, motivation, and enthusiasm needed to succeed in other areas of life. C-sections top the list of surgeries in hospitals, and hysterectomies and mastectomies are increasingly common. Breast cancer remains the most prevalent cancer type. Many young women use birth control due to hormonal imbalances, and recent studies show that nine million people in our country use antidepressants. Women's natural life cycles—menstruation, pregnancy, and menopause—are often treated as medical conditions. However, it's possible for women to find healing, energy, pleasure, and longevity in every phase of life through safe, natural methods. Our ancestors did it—so why can't we?

fostering solidarity with other women on the community level, reclaiming values traditionally associated with the feminine[193], and internalizing them.

In essence, these practices aimed to reconnect women with emotions that modern society often pushes to the background. They helped women engage in practices that supported embodiment—the process of becoming more attuned to one's physical and emotional body. In a capitalist, patriarchal system that governs work, education, and healthcare, which ignores the unique embodied experiences of women, these practices provided a way for women to recognize their own bodily experiences, see the possibilities these experiences offered, and form a new relationship with their bodies based on a biopsychosocial (BPS) perspective. Some of these practices fell under the category of TCAM as mentioned earlier, while others, like yoga and meditation, are generally accepted holistic body approaches. In this section, I will focus on the impact of alternative healing practices and holistic body approaches on women's embodied experiences.

A participant from the fieldwork, Şükran's story reflects key concepts from feminist health studies and the psychosomatic understanding of health, particularly in relation to women's reproductive health. We can conceptualize Şükran's experience through embodiment theoretical frameworks and the BPS model to healing. Diagnosed with poly-cystic ovary syndrome and unable to menstruate without medication for years, Şükran began her journey through a seminar where she learned to trust her body.

> I started with different techniques, but later it evolved into a more psycho-spritual path and continues on this trajectory. Specifically, my initial departure point for this journey was the fact that, for many years, I couldn't menstruate naturally without medication due to a poly-cystic ovary diagnosis. I attended a short two-day seminar on women's wisdom. There, we explored what it meant to connect with oneself, and it was very beneficial for me.

[193] Feminine values are described in Hart's book "*Body of Wisdom: Women's Spiritual Power and How It Serves". the book is* based on the belief that qualities such as yearning, beauty, harmony with the Earth, nurturing, cleansing, and recognizing the sacredness of life are feminine values and powers. It calls women to reconnect with their feminine nature through this perspective. This book is one of the sources mentioned in various womb healing trainings or workshops and is often included in recommended reading lists for such programs. The book argues that these aspects of women's nature are not seen as strengths in patriarchal society; instead, there is a prevailing value system that diminishes women's abilities (Hart, 2013).

Encouraged by this, I stopped taking the medication, and for the first time, I had a menstrual cycle without medication. It was a very powerful and effective seminar for me. From that point on, I decided to advance on this path. For the first time, I felt a deep connection to my uterus, my ovaries, and my body, which was very healing for me. Understanding the meaning of my cycle was profound. Therefore, I continued on this path, feeling that the healing of my uterine issues would come through emotional and personal work related to women's wisdom.[194] Şükran

I heard this during a personal development workshop. They said, "You need to recognize these feminine qualities within yourself. You need to work on this." And indeed, the woman leading the seminar was very successful. I was really happy because, after just a two-day seminar, she made such a difference that I had the courage to stop taking my medication. You can think of it like a women's circle, where everyone shares their experiences about their own femininity. What challenges do they face? What's going on? It was about creating a connection—connecting with your feelings and emotions. It only took two days. It's been a long time, so I don't remember everything, but it was centered around sisterhood. We explored where the womb and ovaries are in our bodies, using our hands to feel where they are. We focused on feeling their vitality, warmth, and energy. Until that point, I hadn't realized that I carry something like this inside me. I have female reproductive organs, and carrying something within me that creates a cycle, feeling it, made me feel really good. I think that was my first turning point. We closed our eyes, and accompanied by some mantras, we connected emotionally inward, engaging in introspective techniques. The essence of it was really about focusing on our bodies and our femininity. At the end of the first month, I told the group, "I'm not taking the medication anymore, and I got my period," and they were all so happy. It felt like a miracle. After that, I started exercising, and that helped too. I never went back to the medications after that.[195] Şükran

[194] Farklı tekniklerle başlamıştım ama bunu daha sonra biraz daha psikospirütüel yola evrilmiş durumda. ve devam ediyor. özellikle bu yola ilk çıkış noktam da uzun yıllar polikistik over teşhisi ile, kendiliğinden ilaç olmadan adet göremiyordum. kadın bilgeliği üzerine kısa bir seminere gitmiştim iki günlük. orda böyle kendimle bağ kurmanın ne demek olduğu konusunu işledik ve bana çok iyi gelmişti. oradan cesaretle ben ilaçları bırakıp, ilk kez bir adetimim ilaçsız olmuştum. çok kuvvetli etkili bir seminer olmuştu o benim için. ondan sonra da bu yolda ilerleme kararını, aslında o zaman vermiş oldum. çünkü ilk defa rahmim, yumurtalıklarım, kendi bedenim üzerimden hislerimi algılamak bana çok iyi geldi. döngümün ne demek oldugunu farketmek. ve o yüzden, özellikle kadın bilgeliği konusunda rahim üzerindeki rahatsızlıklarımın şifalanmasını, kendimle duygusal anlamda hem de kişisel olarak çalışmakla olacağı hissi geldiği için devam ettim. Şükran

[195] *Gittiğim bir kiişsel gelişim çalışmasında duymuştum. dedi ki aslında senin bu dişi özelliklerini fark etmen gerekiyor hani. bunla ilgili bir çalışma yapman gerekiyor. hakikaten de gittiğim kadın çok başarılı idi. iki günlük bir seminer ile bu kadar fark yaratabileceğini ve bana o ilaçları bırakma cesareti gösterebildiği için gerçekten mutluyum. bir kadın çemberi gibi düşünebilirsin. o çemberde herkes kendisine ait kadınlığı ile ilgili paylaşımlarda bulunuyor. nasıl sıkıntıları var? neler var? yani bir bağ kurmak aslında. hani kendi hislerinle duygularla bağ kurma üzerineydi. iki günde. çok uzun zaman oldu, çok hatırlayamıyorum ama kızkardeşlik üzerineydi. rahim, yumurtalık nerede? elimizle bedenimizde nerede olduğunu hissetmek. onun canlılığını, ısısını, ateşini, işte hissetmek yani. aslında ben o zamana kadar şunu fark ettim. benim dönüm noktam o oldu. içimde böyle bir şey taşıyorum.*

Embodiment, as discussed by Sullivan (2001) and Grosz (1994), emphasizes how the body is not merely a biological entity but is shaped by personal, social, and cultural experiences. In this context, Şükran's connection to her uterus and ovaries, through psychosomatic and emotional work, highlights the role of women's lived experiences in their healing processes. Şükran's realization of the "meaning of her cycle" resonates with feminist critiques of biomedical approaches that often neglect the emotional and experiential aspects of women's health. Nancy Krieger's (2005) concept of 'embodiment' also speaks to this holistic understanding of health, suggesting that the social and emotional dimensions of one's life are connected to physical health outcomes. Şükran's journey from medicalized treatment (medication for polycystic ovaries) to a more self-aware and emotionally driven healing practice aligns with this approach, illustrating how health is not only about treating symptoms but also about addressing emotional and psychosocial factors. Şükran's shift towards a holistic healing approach, where emotional and spiritual dimensions play a central role, echoes Mate's (2019) work on the mind-body connection. Mate argues that unresolved emotional issues, such as stress and trauma, may manifest in physical symptoms, and healing requires addressing these root causes rather than just the symptoms. Şükran's decision to stop medication and her success in regaining her menstrual cycle can be seen as an outcome of this integrated approach to healing, where psychosomatic factors play a crucial role.

Miller (2006) also discusses the importance of addressing emotional and spiritual aspects of health, particularly in women's reproductive issues. Miller's propositions align with Şükran's experience, showing how engaging with 'women's wisdom' and reconnecting with one's body can lead to transformative health outcomes. The concept of self-healing, namely empowering individuals to trust their own bodies, also aligns with the biopsychosocial model that values personal agency and emotional work as essential components of healing.

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kadınlık organım var. eeeee.... (düşünüyor) böyle bir döngü yaratan içimde bir şey taşımak, onu hissetmek bana çok iyi gelmişti. farkettim aslında ilk dönüm noktası bence oydu yani. gözlerimizi kapatıp bazı mantraların eşliğinde duygusal olarak o içe bağlanmayı, içe dönüşü daha doğrusu. içe dönüş teknikleri... ama işin özünde biraz daha kendi bedenimizi ve kadınlığa odaklanılan bir programdı. ilk bir ayın sonunda da ben bu ilacı içmiyorum, adet gördüm diyerek haber vermiştim, çok sevinmişlerdi grup olarak. mucizevi bir şeydi. sonra spor yapmaya başladı. egzersizin de etkisi oldu. sonrasında da bir daha ilaçlara geri dönmedim.

In many women's womb retreats and workshops, women are encouraged to reconnect with their bodies. But what does it mean to connect with one's body, and how is it achieved? This concept involves developing bodily awareness, often referred to as "embodiment," as conceptualized by feminist scholars. These includes practices such as abdominal massage[196], Mayan massage[197], self-massage techniques, Abhyanga[198] (applying oil to the body), Yoni Massage[199], and dry brushing[200] the entire body. These practices aimed at promoting healing, relaxation, and a deeper connection to the female body to increase physical awareness, helping women become more attuned to their body's sensations, desires, and aversions. These massages and touches help women form a stronger relationship with their "embodied" body, thus enhancing their ability to understand and feel what their bodies want or reject.

In addition to massages, other examples of body awareness practices include dancing and practicing yoga. Rather than engaging in mechanical, structured movements,

196 Abdominal massage, an ancient practice across cultures, involves gentle palpation of the abdomen to promote physical and psychological well-being. For women, it has been shown to alleviate menstrual cramps, reduce heavy bleeding, and offer stress relief. When combined with essential oils, such as clove, cinnamon, lavender, and rose, it may enhance these benefits, improving both physical comfort and mental tranquility.By gently palpating the abdomen, this method promotes overall wellness and can be easily integrated into daily self-care routines(Hills, 2019).

197 Mayan massage is a form of Arvigo® Therapy which is a potent form of bodywork that combines the foundational principles of Central American sobada with a wide range of bodywork techniques aimed at promoting reproductive, digestive, structural, and spiritual health. This approach blends traditional knowledge with modern anatomical insights, offering a powerful method for bridging different healing traditions and supporting human well-being in today's complex world.

198 The practice of applying sesame or coconut oil to the body is known as **Abhyanga** in Ayurvedic medicine. It is a form of self-massage using warm oils to nourish the skin, improve circulation, and promote overall wellness.

199 Yoni massage is a therapeutic and intimate practice aimed at promoting healing, relaxation, and a deeper connection to the female body, particularly the genital area. Derived from the Sanskrit word "yoni," meaning "sacred space," this massage focuses on the vulva and vaginal regions. It is often used in holistic or Tantric practices to release emotional tension, enhance sexual well-being, and support trauma healing. While intended to honor and reconnect women with their bodies, yoni massage should always be performed with respect, consent, and in a safe, professional environment.

200 Dry brushing is a technique that involves brushing the skin with a dry, stiff-bristled brush to exfoliate and stimulate circulation. This practice is believed to help remove dead skin cells, improve lymphatic drainage, and promote detoxification by encouraging the flow of lymph fluid. Many people use dry brushing to enhance skin texture, reduce the appearance of cellulite, and invigorate the body. It is typically performed before bathing, moving the brush in gentle, upward strokes toward the heart to maximize the benefits.

women are encouraged to dance or move in a way that feels intuitive and authentic to them. *Tantric Dance*[201] is one for the styles that is adviced to women for healing. This allows for deeper embodiment, where women become more familiar with their bodies' sensations, such as pleasure and pain. These embodiment practices can also support women in dealing with the physical sensations experienced during menstruation, including discomfort or pain. Similarly, during menopause, being more aware and accepting of the body's changing sensations is emphasized as an important aspect of the process.

One significant aspect of this discourse is the cyclical nature of the female body. Unlike men, women's bodies go through distinct hormonal phases throughout the menstrual cycle, each phase bringing its own psychological and social needs. This highlights the unique experiences offered by the female body, inviting a deeper understanding and awareness of its rhythms.

The cyclical nature of the female body refers to the regular, recurring physiological changes that occur in women, most notably through the menstrual cycle. This cycle typically lasts about 28 days (+- 5 days), although it can vary, and it is divided into four main phases: the menstrual phase, follicular phase, ovulation, and luteal phase.

1. Menstruation is the shedding of the uterine lining, which occurs if there is no pregnancy.
2. Follicular phase is when the body prepares for ovulation, with hormone levels rising and follicles in the ovaries maturing.
3. Ovulation is the release of an egg from the ovary, around the middle of the cycle.
4. Luteal phase is when the body prepares for a potential pregnancy, or, if fertilization does not occur, hormone levels drop, leading to menstruation.

[201] Tantric Dance is a Neo-Tantric practice that involves spontaneous and improvised movement, where masculine and feminine energies are believed to harmonize through the symbolic union of the deities Shiva and Shakti. Rooted in the spiritual tradition of Tantra, this dance is viewed as a way to transcend duality and connect with deeper levels of consciousness. For women's health, Tantric Dance is said to promote emotional release, enhance body awareness, and foster a sense of balance and empowerment. By engaging with one's feminine energy and embracing sensuality, the practice may help women reduce stress, cultivate self-love, and strengthen their mind-body connection. Additionally, it can serve as a therapeutic tool for exploring emotional blockages, enhancing intimacy, and promoting overall well-being.

This cyclical process is regulated by hormones like estrogen and progesterone, and it affects not only physical functions but also emotional and psychological states. It reflects the body's natural rhythm and its connection to fertility, reproduction, and overall health. Women's experiences, energy levels, and emotional states may vary across the different phases of the menstrual cycle, highlighting the unique cyclical nature of female biology. This cyclical nature of the menstruation, which is governed by hormones, not only influences physical health but also impacts emotional and psychological well-being. This connection emphasizes how the menstrual cycle mirrors larger natural rhythms, such as the lunar phases and seasonal changes, reflecting the profound link between the female body and broader environmental cycles, as Northrup indicates:

> The menstrual cycle is the most basic, earthy cycle we have. Our moon cycles and our blood are our connection to the archetypal feminine. The macrocosmic cycles of nature—the waxing and waning of the moon, the ebb and flow of the tides, the changes of the seasons—are reflected on a smaller scale in the menstrual cycle of the individual female body. (Northrup, 2010, p. 361)

Reflecting on my fieldwork observations and experiences in women's circles, healing arts camps, and certification programs, a common theme emerges: the emphasis on recognizing women's bodily experiences. For instance, in the context of menstrual health, women are encouraged to pay attention to the natural cycle of their menstrual periods. Each menstrual cycle consists of four distinct phases, which are defined by hormonal changes and are also discussed in relation to psychological and social connections.This brings us to Cycle Awareness.

> The female uterus acts like a compass aligned with the cycles of the Earth and the Moon. Awareness of the menstrual cycle serves as an internal guide and a tool for self-care, offering insights into both physical and emotional health. Living in harmony with the rhythm of menstrual cycles can enhance energy levels, creativity, and productivity. Therefore, if a woman wishes to understand herself better, she should closely familiarize herself with her menstrual cycle and the unique patterns within it.[202] (Telek, 2021, p.205)

[202] The quotation is my own translation. The Turkish original is: Kadın rahmi, yeryüzünün (ve ayın) döngülerien uyumlanmış bir pusula gibidir. Adet döngüsü farkındalığı bir kadın için içsel rehberlik ve öz bakım aracıdır; fiziksel ve duygusal sağlığımıza dair ipuçları verir. Menstrual döngülerin ritmiyle uyumlu yaşamak enerji seviyemizi, yaratıcılığımızı ve üretkenliğimizi artırır. Dolayısıyla bir kadın

Cycle awareness refers to the understanding of the physical, emotional, and energetic changes that occur in a woman's body throughout the menstrual cycle, particularly during the phases between ovulation and menstruation, driven primarily by fluctuations in estrogen and progesterone. With this awareness, women can recognize that they undergo cyclical changes every month and learn to track these changes, allowing them to understand their varying needs and organize their daily lives accordingly.

As Northup discusses, much like the phases of the moon influence tides, the hormonal changes in a woman's body between menstruation and ovulation also impact her physical, psychological, and social well-being. By being mindful of and aligning with these changes, women can not only enhance their quality of life but also positively impact their health. The "Inner Seasons" approach (Pope & Wurlitzer, 2017), which likens the four phases of the menstrual cycle to the seasons of summer, autumn, winter, and spring, highlights the psychological and social dimensions of menstruation. While biomedicine and society often reduce menstruation to mere biological 'bleeding,' this perspective emphasizes the broader significance of the menstrual cycle beyond its physical function. This perspective align with the Engel's biopsychosocial model of medicine. I argue that the menstrual cycle can be understood through a biopsychosocial lens, where hormonal changes throughout the cycle correspond to shifts in physical, emotional, and social well-being.

One popular framework that conceptualizes this is the "Inner Seasons" model (Pope & Wurlitzer, 2017), which divides the menstrual cycle into four phases: Inner Winter (menstruation), Inner Spring (follicular phase), Inner Summer (ovulation), and Inner Fall (luteal phase). These phases not only reflect hormonal fluctuations but also mirror seasonal changes, offering insight into the psychological and social dimensions of menstruation.

Inner Winter corresponds to the menstruation phase (days 1-6), when energy and hormone levels are at their lowest. This phase is marked by introspection and rest,

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kendini bilmek isterse, adet döngüsünü ve bu döngü içindeki kendi biricik örüntüsünü yakinen tanımalıdır (Telek, 2021, p.205).

where self-care and reflection are encouraged. Traditionally, this time has been seen as a period of spiritual renewal, where women are thought to have heightened access to their inner wisdom. The focus is on self-nurturing rather than outward productivity, allowing for rest and recuperation (Aiyana, 2021) .

Inner Spring, the follicular phase (days 7-13), is associated with renewal and growth. As estrogen levels rise, women may experience increased energy, optimism, and motivation. This phase is ideal for new beginnings, such as starting projects, engaging in physical activities. It parallels the social archetype of the Maiden or Goddess, symbolizing re-emergence and revitalization.[203]

Inner Summer, the ovulation phase (days 14-21), represents the height of social energy and fertility. During this phase, women may feel more outgoing, expressive, and engaged in relationships. This phase aligns with the Mother or Healer archetype, emphasizing community-building, nurturing, and creativity. It is a period of heightened fertility, making it a critical time for reproductive health considerations, but it also reflects peak emotional and social vitality.

Inner Fall, the luteal phase (days 22-29), marks the winding down of energy and the return to introspection. The phase is associated with the Wild Woman or Priestess archetype, a time of inward focus, creativity, and boundary-setting. Women may feel more sensitive to demands and more inclined toward self-care as the body prepares for the next menstrual cycle. If self-care is neglected, this phase may exacerbate symptoms of PMS (Aiyana, 2021) .

203 Archetypes and mytology have been used in theliterature on women healers. Jeanne Acterberg analyzes the history of medicine and healing in an interdisciplinary way. In her book "Women Healers" which is a manifestation for the need to requestion the practices of modern medicine and a call for an integration of female values with the medicinal science. While folk medicine has generally been considered as "domestic", Acterberg's book points out the cosmological meaning of healing through history. The serpent held in the hands of Asklepious, the god of healing in Greek and Roman mythologies, is the mythological entity referred to in healing. Likewise, Şahmeran is the goddess of healing in Turkish mythology and it is the mythological entity referred to in the treatment of many diseases. The serpent is also a symbol of God of good health. Apart from these, it is the duty of women healers to look after the patients, to guide women to give birth and to send the dead to their last sleeps as in tribal culture. The basis of the cosmology of the Former Greek culture, the Roman culture, and early Christian culture in medieval Europe was the science of healing (Achterberg, 2009, p. 10-18).

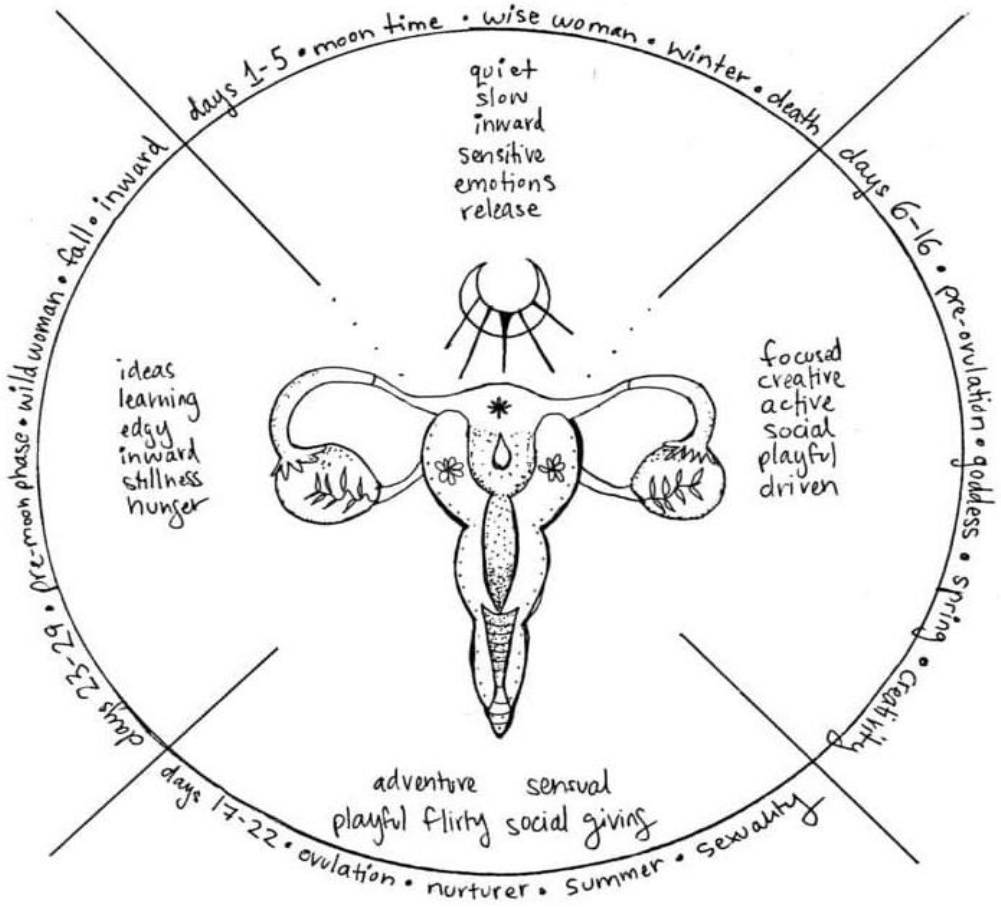

Figure 4. Archetypes and Seasons Within Women's Monthly Cycle, the figure is taken from https://risingwoman.com/4-archetypes-of-the-female-cycle/

By understanding and aligning with these cyclical phases, women can enhance their well-being, improve their quality of life, and foster a healthier relationship with their bodies(Pope & Wurlitzer, 2017). This model of the menstrual cycle highlights the interconnection of hormonal changes with emotional, psychological, and social experiences, as a result I conceptualize the "Inner Seasons" model of menstrual cycle as a biopsychosocial (BPS) model. This narrative of the menstrual cycle as a series of 'seasons' provides a valuable perspective on women's embodied experiences. While traditionally viewed as a purely biological process, the menstrual cycle also has profound psychological and social dimensions. The interplay between these biopsychosocial aspects suggests that aligning with each phase of the cycle, such as resting adequately during the 'winter' phase of menstruation, can promote better health and overall well-being.

For instance, it is believed that if a woman honors her need for rest during menstruation, she will feel more satisfied and maintain better physical and mental health, as exemplified by my interlocutors too. Conversely, if she pushes herself to be overly social or engage in strenuous work during this time, she may experience fatigue, emotional strain, and a general sense of dissatisfaction. Considering the capitalist system's emphasis on hard work and the demands of wage labor, which conflict with women's cyclical nature, we can say that women often exhaust themselves by being expected to maintain high levels of performance, even during phases of their cycle when their bodies naturally require rest such as during menstruation. This constant pressure to perform at maximum capacity, even when their energy levels are at their lowest, places additional strain on women, particularly during at least one week of the month.

An example of this consciousness goes parallel with most of the interlocutors from my fieldwork such as Şükran, Türkan, Dijan, Gönül etc. After practicing womb healing methods and aligning with their body, they have noticed that as their menstrual cycle approaches, they feel the need to slow down and shift to lighter forms of exercise. They seek out calmer environments and incorporate relaxing practices, such as womb meditation, into their routine before their period begins. By doing this, they report experiencing the menstrual days with greater ease and comfort. This perspective can be seen as part of a broader cultural shift, calling for the recognition of women’s bodily experiences and the importance of living in harmony with them both in terms of embodied experiences and social life circumstances.

Pelvic floor dysfunctions, such as pelvic organ prolapse or incontinence, can be examined through the lens of embodiment. Rather than seeing these conditions solely as biological issues, the framework would consider how societal pressures, gendered expectations, and even past trauma contribute to the physical manifestation of these conditions. For example, childbirth practices, the cultural emphasis on motherhood, and the stigma around discussing pelvic health can all exacerbate or mitigate these dysfunctions. Sullivan’s concept of embodiment emphasizes that these dysfunctions are not merely biological but are also shaped by gendered experiences and social

conditions. A woman's pelvic floor issues could be understood as the embodiment of societal norms and sexist practices, rather than just a result of physiological factors. Sullivan's critique of the biology-culture dualism can be used to understand how these disorders are not just biological malfunctions but are also shaped by lived experiences of sexism, stress, and trauma.

Moreover, this denial of the recognition of the uniqueness of female embodiment may have developed a perspective that harms women's relationship with their bodies. It is possible that this perspective may have a negative impact on women's self-perception and body image, including the difficulty of acceptance of their menstrual cycle. Sullivan suggests that the lack of supportive discourses that facilitate female embodiment on its own terms contributes to women's struggles with shame and negative experiences of their bodies (Sullivan, 2001).

Based on this awareness, several practices are employed to reconnect with the womb by the interlocutors. Examples include the yoni spa, yoni egg, and, most importantly, keeping a journal to track the menstrual cycle's four phases. One of my interviewees mentioned that in addition to this general cycle journal, she also keeps a specific 'womb journal' as a way to cultivate a deeper connection with her womb. Through this practice, she actively engages with her body and its cycles, enhancing her awareness and relationship with her womb.

> I kept a womb journal, and it was really helpful for me. I bought a notebook and started writing as if my womb was speaking to me. I have a notebook and a pen, and I named it my 'womb journal.' It became part of a technique. I would write whatever came to mind at that moment. My womb would say, 'You've never thought about me until now. You haven't cared for me, you haven't given me enough support.' And when I looked at what I had written, I realized that I had never paid attention to my womb before. I hadn't even asked it how it was doing. Of course, it had grown distant from me (laughs). That's what I figured out. Reconnecting with my womb happened through my womb journal. It was a very spontaneous thing. If you ask me how, I'd say it's different for everyone. I would ask my womb, 'What do you want? What kind of care do you need? Do you want me to touch you, remember you, do Kegel exercises throughout the day, or something else?' The Kegel exercises were also a very important technique. But this bond I formed with my womb, it was through the journaling process that my womb showed me how to

connect. The more I wrote, the stronger the connection became. That's how I can explain it.[204] Şükran

Me: When you say the connection became stronger, what do you mean?

The connection with my womb, with my womanhood. I had ignored it until now. Gradually, I began to bring back something I had been neglecting. I didn't know if it had ever existed before, but I brought it to the surface. And I realized, 'This is something beautiful. I have a rhythm, a cycle aligned with the moon.' With my womb journal, I also became aware of when I ovulate, when I menstruate, and when it ends. This practice made me aware of my cycle. I'd also write about my feelings. For instance, when my period starts, I write down how I feel. I might not want to do anything, I might feel unwell. This phase is often called the 'winter' of the cycle. When my period ends, I feel a bit better, a bit more alive. That's 'spring,' as I slowly regain my energy. After that, ovulation comes, which is my most active time. It's the phase where I feel most alive as a woman, full of energy to do anything, whether it's work, projects, or other things. After that comes 'autumn,' when I start turning inward again, organizing my home and preparing for 'winter.' As I go through these phases, I also notice things like my weight and my nutritional needs. It's a multi-dimensional experience. It's like magic. I've seen its magic in my life. I can say it's been essential for me, a deeply healing method. It's very, very valuable to me, and I am still journaling to this day. I am truly grateful.[205] Şükran

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[204] ve rahim günlüğü tutuyordum. o da çok iyi geldi bana. bir defter aldım. ve rahmim benimle konuşur gibi yazdım. defterim ve kalemim var. "rahim günlüğü" diye adlandırdım. bu da bir tekniğin içinde. o an ne geliyorsa yazıyordum. Rahmim: "bu zamana kadar beni hiç düşünmedin. benimle ilgilenmedin, bana yeterli desteği vermedin. hakikaten de yazdıklarıma bir baktım. ben o zamana kadar rahmimle hiç ilgilenmemişim. ona nasıl olduğunu sormamışım. o da tabi bana küsmüş yani (gülüyor) öyle bir şey çıkardım. onunla bağ kurmak benim rahim günlüğüm ile olud. çok spontan bir şey. nasıl olur derseniz. herkeste farklıdır. ona soruyordum, ne istiyorsun? nasıl bir bakım istiyorsun? elimi dokunmak mı, seni hatırlamak mı, gün içinde kegel egzersizi ile seni hatırlamak mı, bu nasıl olursa.... kegel egzersizi de çok önemli bir teknikti. ama öyle bir bağ kurmak , nasıl bağ kuracağımı aslında günlük yazma aracılığı ile rahmim bana söyledi.yazdıkça da o bağ kuvvetlendi. öyle diyebilirim

[205] Ben: kuvvetlendi dedğin şey ne oluyor?
R: rahim ile olan bağım. kadınlığım ile olan. bu zamana kadar yok saymışım. aslında yok saydığım bir şeyi yavaş yavaş geri getirdim. öyle bir şey önceden var mıydı bilmiyordum. onu yüzeye çıkardım. ne güzel aslında bu varmış. ne güzel bir dengem varmış. hormonlarım varmış. kadınlık üreme organım var. bir periyodum var. daha doğrusu şeyi anladım. aslında benim bir ritmim var. benim bir döngüm var ay ile uyumlu oldğum. bir kere rahim günlüğü ile birlikte şeyi de farkettim. ne zamna yumurtluyorum, ne zamna regl oluyorum. ne zamna bitiyor. böyle bir döngünü farkındalığını da bu yazılar ile çıkarmış oldum. yazdıkça oradaki hissiyatlarım da. örneğin, diyelim ki tam regl oldum, ne hissediyorum, onları da yazıyorum. canım bir şey yapmak istemiyorum. iyi değilim. bu regl olunan döneme kış mevsimi diyorlar. regl bitiyor, biraz iyi hissediyorum. hafif bir canlılık geliyor. ona ilkbahar, yavaş yavaş toparlanıyorum. o bitiyor. ondan sonra yumurtlama zamanım geliyor. tam böyle en aktif olduğum zaman. bir kadın olarak canlı olduğum, her şeyi yapabilecek enerjimi hissettiğim. iş olur proje olur başka bir şeyler olur. onları yapabilme kapasitemin ne kadar geniş olduğunu gördüğüm bir evere. sonrasında sonbahar. o zamna biraz içe dönüş. biraz daha evimi toparladığım. içe döndüğüm. kendimi "kışa" hazırladığım bir dönem. öyle dönemden geçtiği ve ordaki duygu durum varken aynı zamanda, kilom nasıl, nasıl bir beslenme isteği, ihtiyacım var. bunlar da ortaya çıkıyor.

In this reflection, the concept of womb healing emerges as a deeply personal, intuitive practice where the individual reconnects with their body and womanhood through journaling and bodily awareness. Şükran's experience highlights that womb healing goes beyond the physical realm, involving emotional and spiritual dimensions, much like holistic healing practices that integrate mind, body, and soul. By keeping a womb journal, she personifies her womb, engages in a dialogical process, and establishes an intimate connection with her menstrual cycle, hormones, and feminine energy. This process aligns with practices such as cycle syncing, where women tailor their activities, nutrition, and self-care according to the natural phases of their menstrual cycle, linking phases of the menstrual cycle to the seasons. The awareness gained from her writing allows her to notice shifts in her energy, mood, and needs, which are often neglected in modern living.

These techniques all aim to nurture the pelvic area, restore balance in the womb, and help heal any emotional or physical traumas stored there. Through this healing, Şükran reconnects with her womb, regains a sense of rhythm, and experiences a shift in her awareness, which she describes as magical and healing. This demonstrates that womb healing practices, whether through *journaling*, movement, or mindfulness, offer a holistic path to reclaiming and nurturing one's womanhood, fostering balance and empowerment. This experiential method connects well with the broader practices of womb healing, which often involve techniques like yoga *asanas*, physical exercises such as Kegel exercises, massage, and nutrition, as one of the interlocutors indicates:

> Kegel exercises were already a significant technique, but nutrition is also critical and can be considered part of the technical approach. During that period, we completely eliminated dairy products from my diet. I became more conscious of eating clean, non-GMO products, opting for fruits and vegetables free of chemicals. The reason we cut out dairy, in particular, was due to the presence of artificial hormones in animal products. Since the animals are not fed naturally, and because they are often fed GMO products, consuming animal products introduces artificial estrogen into our bodies. The issue I faced was that the artificial estrogen I was getting externally was too

çok boyutlu bir şey ortaya çıktı. büyülü bir şey. sihrini gördüm hayatımda. benim hayatımda çok elzem olduğunu söyleyebilirim. çok şifalandırıcı bir yöntem olduğunu söyleyebilirim. çok çok değerli benim için . hala daha yazmayı bırakmış değilim. Şükran

high, and my body couldn't produce enough progesterone to balance it out. When they gave me artificial progesterone in a sudden high dose, it suppressed ovulation by overriding the estrogen levels. This is essentially what happens with PCOS, which in simple terms means being unable to ovulate. The problem wasn't that my estrogen was too low but that it was being elevated by artificial sources, and my body's natural progesterone wasn't able to rise enough to counteract it. This is what prevented ovulation. After understanding this technique, the solution became clear. Nutrition was key—eliminating dairy and products containing chemicals. This applied to everything, from my personal care products to the food and drink I consumed. Even things like nail polish and the cleaning products I used in my home were considered. It was a holistic approach, addressing everything altogether.[206] Hayrünnisa

…

I realized that not everything is solved with medication; my body needed to be noticed. I think that was the most important turning point for me. That's how my understanding developed—I have a body, and it needs to be acknowledged and cared for, not ignored. Up until then, I had seen that I had actually been neglecting everything—my womanhood, my sexuality. I became aware of these things, and then I started paying attention to them.[207] Jale

...

I changed everything I ate, drank, and used all at once. I no longer had the patience for that cycle irregularity. The last time I was diagnosed with polycystic ovary syndrome was in 2017. My cycle continued for a while, then stopped again. That's when I sought this guidance. Supplements, nutrition, avoiding chemicals, Kegel exercises, yoni spa treatments, and diet changes

206 kegel vardı teknik olarak. bir de beslenme. beslenmeyi de teknik kısma yazabiliriz diye düşünüyorum. önemli ve kritik. süt ve süt ürünlerini tamamen o dönemde kesitk. içeriği temiz ürünler yemek. gdo'suz. içinde kimyasal olmayan sebze meyve tarzı yemeğe başladım. bilinçlendim. özellikle süt ürünlerini kesme sebebimiz de hayvansal gıdalarda yapay hormon var. hayvanların besleniş biçimleri de doğal olmadığı için. onları gdolu beslendiği için, hayvansal ürünler de bize yapay östrojen olarak geliyor. aslında sorun, dışardan yapay östrojen ile yükseltmem ve progestorenun da yeteri kadar yükselememesi. ani bir şekilde yüksek yapay progestorenverdikleri zaman, hani östrojen üzerine çıkıp yumurtlamamayı sağlıyor. polikistik over yumurtlayamama, türkçesi bu. yumurtlayamama sebebim östrojenimin az olması değil. östrojenimin yapay, dışardan aldığım şeylerden çok fazla yükselmesi ve progestorenumun onu yeterli düzeyde karşılık verememesi. ve yumurtlama olmuyor. problem buydu. bu tekniği anladıktan sonra burda yapılması gereken işte bu. Beslenme, süt ve süt ürünleri. işte dışardan aldığım içinde kimyasal olan ürünler. bunlar benim kişisel bakım ürünlerimden tut da yediğim içtiğim, ojeden, evimde kullandığım temizlik malzemesine kadar her şeyi kapsayan. ... çok bütünsel bir bakış açısıydı. hepsi yani

207 Her şeyin ilaç olmadığını, bedenimin farkedilmeye ihtiyacı olduğunu anladım. bir kere bence en önemli kavrama noktam o oldu. idrakim öyle gelişti. bir bedenim var. onun fark edilmesi ve ona ilgi gösterilmesi gerekiyormuş. yok sayılmaması. ben şimdiye kadar kadınlığımı, cinselliğimi herşeyi aslında yok saymış olduğumu gördüm. bunları fark ettim, ve sonra ona ilgi gösterdim. Jale

> were all part of it. At the same time, I began questioning the psycho-spiritual root cause of what I was experiencing—this was also a confrontation with my own womanhood and my body.[208] Safiye

These excerpts form the interlocutors reflect a holistic approach to healing, emphasizing both physical and emotional dimensions, as in the BPS model. We can talk about an embodied awareness in the sense that women have gone through a realization of the need to acknowledge and care for their body (and womanhood) instead of neglecting it. This shift in perception marks a turning point for the interlocutors, where they become conscious of their body's needs and its connection to their reproductive health. There is an exploration of the root causes of health issues from a psycho-spiritual perspective, which involves confronting one's womanhood and past traumas. This introspective approach complements physical healing and fosters a deeper connection to the body. The excerpts critique reliance on medication alone and underscore the importance of alternative, natural approaches to healing. The integration of nutrition, lifestyle changes, and holistic self-care presents a contrast to conventional medical treatments for conditions like PCOS.

4.4.2. The Role of Women's Circles in Shaping New Forms of Relationships

As part of my participant observation, I selected several online platforms in Turkey for observation and analysis, including mainstream media websites as well as Facebook and Instagram pages. These platforms provided valuable insights into women's experiences, particularly in personal story-sharing groups centered on menstrual cycles, PCOS support, womb sciences, and women's circle practices. I began by following relevant pages on Facebook and Instagram, consistently monitoring the issues that were gaining prominence within these online communities. Through my observations, I found that communication and solidarity play a crucial role in supporting women during their healing and treatment processes. Asking questions and listening to each other's experiences have become important channels

208 Hem yediklerim içtiklerim. kullandığım hersey bir anda değiştirdim. artık daha fazla tahammülüm yoktu o döngü düzensizliğine... benim en son 2017 de yine polikistik over çıkmıştı. bir süre döngüm devam etti, sonra yine durdu. o zaman bu danışmanlığı aldım. destek takviye ürünleri, beslenme, kimyasallardan uzaklaşma, kegel, yoni spa, beslenme, bunlar. aynı zamanda da psiko-spiritüel olarak da bu yaşadıklarımın kök nedeninin ne olabileceği konusunda da bunu sorgulama .. bir yüzleşme. kendi kadınlığım ile bedenim ile bir yüzleşme de yaşadım. Safiye

for women. By engaging in long conversations and sharing personal experiences, they build a social network, creating a collective space of support. When compared to the biomedical model's suggestion of two dimensional, authoritative, doctor-patient relationship, in holistic models women are seeking a different kind of relationship with themselves, with health practitioners and also among the women who share similar health problems.

Women's circles, a core element of the Mystical Femininity Trainig (*Gizemli Dişilik Eğitmenlik Programı*), provide an important space for learning and practicing coping skills, as well as challenging the cultural and social norms about the gender roles. As part of the Mystical Femininity Trainig, these circles, held regularly via Zoom every 15 days, range in size from intimate gatherings of 3-5 participants to larger groups of up to 10. During these sessions, women share personal experiences, express their feelings, and reflect on the outcomes of the practices they engage in. As Telek (2021) notes, "Circle practice is a ritual" (p. 342). Participants are encouraged to "be present, listen deeply to yourself, the space, and life, bear witness, and express from the heart the aliveness you witness and feel" (p. 343).

Women's circles were sacred gatherings where women come together to share, support, and empower one another. Rooted in ancient traditions, such as Indigenous Moon Lodges and menstrual huts depicted in *The Red Tent*[209] by Anita Diamant, these spaces have long been a place for women to retreat, exchange wisdom, and celebrate rites of passage (Diamant, 1997). Despite centuries of patriarchal rule, women have always found ways to connect in community, raising children together, passing down knowledge, and honoring their collective experiences. In contemporary women's circles, the focus is on creating an egalitarian space where all voices are heard and respected. While there may be a facilitator, leadership is shared among all participants. These circles are spaces for personal growth, spiritual development, and healing, allowing women to connect deeply with one another through shared stories,

209 The Red Tent, a historical novel expands on the story of Dinah, a minor character in the Bible, who is the daughter of Jacob and Leah. The title refers to the tent where the women of Jacob's tribe would gather during menstruation or childbirth, finding solidarity and support. As noted in a review by the Los Angeles Times, the novel resonates with readers by giving a voice to one of Genesis's overlooked female figures and celebrating the bonds between mothers and daughters, as well as the mysteries of the life cycle (Dwass, 2000).

meditation, and other practices. In this environment, women find strength in their shared experiences, fostering a sense of sisterhood and community that offers both personal and collective transformation (Levine, 2023).

In ancient wisdom, women have found ways to connect in community, raising children together, passing down knowledge to next generations, and honoring their collective experiences (Achterberg, 1991). In these traditional women's circles, they shared and taught each other ancient wisdom about their bodies, cycles, and processes like menstruation and childbirth, possessing both the knowledge and the power to care for themselves. This communal exchange of knowledge is deeply connected to the themes explored in *Witches, Midwives, and Nurses: A History of Women Healers* by Barbara Ehrenreich and Deirdre English (1973). The book delves into the historical roles women played in healing practices, particularly in reproductive health, and examines how their understanding and authority over their bodies evolved across different eras, especially during times when women were central figures in healthcare. In pre-modern societies, women held significant roles as healers, particularly in matters related to reproduction. They were revered as midwives, herbalists, and caretakers within their communities. Their intimate knowledge of herbs, traditional remedies, and reproductive health practices formed the cornerstone of women's healthcare. However, the book highlights a pivotal shift in women's roles as healers during the transition to modernity, particularly during the era of witch hunts and the medicalization of childbirth. As medical institutions gained prominence, traditional female healers faced persecution and marginalization (Ehrenreich and English, 1973). The witch hunts, in particular, targeted women who possessed extensive knowledge of herbs and healing practices about reproductive health. This persecution not only erased valuable knowledge but also instilled fear, driving women's expertise in reproductive health underground.

The book argues that this historical shift severed the direct link between women and their knowledge of their bodily health. The suppression of traditional healing practices and the dominance of male-led medical institutions contributed to the erasure of women's intimate understanding of their own bodies. Women were no longer the primary custodians of their reproductive health, leading to a disconnection

between their lived experiences (embodied knowledge) and themselves and leading to a more medicalized approach to reproductive care. The transformation of women's knowledge of their reproductive health, as depicted in *Witches, Midwives, and Nurse*s, reflects a historical trajectory where women's wisdom of their bodies and expertise in this realm were devalued and suppressed, ultimately impacting their understanding of their own bodies (Ehrenreich and English, 1973). This background gave me insight into drawing a connection between ancient women's wisdom and contemporary practices. I believe the newly emerging phenomenon of women's circles in Western countries, womb healing workshops, feminine energy retreats, and women's healing arts training can be seen as efforts to revive the transmission of this ancient wisdom that women have lost in the capitalist modern era.

Although the women's circle tradition is rooted in the practices of North American Indigenous peoples, there are echoes of Anatolian heritage in these gatherings as well. Circles offer participants the opportunity to realize that they are not isolated individuals but are deeply interconnected with others. As one participant, Hayrünnisa, reflected:

> I was surprised to see how similar the words of my friends, who I thought were different from me, were to my own. Sitting in the circle, I realized that even those I thought were completely unlike me were actually just like me. The friend I thought was the most similar to me and the one I thought was the least alike are, in fact, one and the same.[210]

In the context of women's circles, there is a tendency to view women's well-being as part of a broader process of collective spiritual evolution. Meditation practices such as womb healing are often incorporated into these circles, as participants believe that an individual woman's healing strengthens her bond with her womb and, in turn, contributes to the collective well-being. As Hart (2013) argues, there is a belief that as one woman heals and connects more deeply with her womb, she supports the collective's evolution and well-being. These circles create a unique space where women can express their individuality while recognizing the shared experiences and

210 benden başka sandığım, yabancı gibi gördüğüm diğer arkadaşların söylediklerine şaşkınlıkla baktım. Çemberde otururken onların da benden başka bşr şey olmadıklarını fark ettim. Bana en benzeyen de , en benzemediği yargısıyla dinlediğim arkadaş da aslında tek'iz.

interconnectedness that bind them, fostering both personal growth and collective empowerment (Levine, 2023). To conclude, women's search for TCAM and alternative healing practices can be read as a sign for a search a new relationship with their bodies, with the meaning of medicine and building and being a part of a community.

CHAPTER 5

ANALYZING MENSTRUAL HEALTH: CONDITIONS, CHALLENGES, AND CARE APPROACHES

My fieldwork highlighted the profound impact of menstrual pain on women's lives. As I conducted my fieldwork, I did not start with the assumption that menstrual pain would be a primary focus. Instead, through open-ended interviews and observations, the issue of menstrual pain emerged naturally from the participants' narratives.

The interviews and participant observations during the fieldwork consistently brought up the topic of menstruation. Whenever women's reproductive health was discussed, the conversations naturally shifted towards menstruation. Every respondent mentioned that they had experienced or were currently experiencing menstrual pain, underscoring both the prevalence and impact of this issue. This finding, which emerged organically from the data, emphasizes the importance of understanding women's experiences with menstruation-related conditions and illustrates how qualitative methodology can reveal critical issues that may not have been anticipated at the outset of the research (Charmaz, 2006; Glaser & Strauss, 1968). The results of the fieldwork on how menstruation is experienced will be presented in the following chapter, *5.1. Menstrual Related Conditions and Normalization of Menstrual Pain.*

In Western societies, women's perceptions and experiences of menarche[211], menstruation, and menopause are shaped by beliefs about femininity, attractiveness, and social value. The natural biological phase of menarche is often not celebrated but rather seen as the beginning of potential embarrassment and concerns about fertility (Bobel, 2019; Koff and Rierdan, 1996; Moore, 1995; Koff et al., 1982). The second

[211] Menarche is the first menstrual cycle, or first menstrual bleeding, time of first period in female humans.

phase of a women's lifetime process, menstruation tends to attract negative remarks, highlighting a woman's reduced capabilities during that time (Jackson & Falmagne, 2013). Some feminist studies evaluated the ways in which social devaluation of women has occurred which is stemming from fears and taboos around menstruation, leading to negative perceptions of female functions (Weideger, 1980; Delaney et al., 1976). Therefore, when women's biological functions are devalued, this leads to that women may devalue themselves due to their perceptions of their own bodies. The societal taboo surrounding menstruation has significant implications for women's health, sexuality, and well-being. The stigma surrounding menstruation not only mirrors but also perpetuates women's diminished social standing (Johnston-Robledo & Chrisler, 2011). However, in their seminal book, *The Curse: A Cultural History of Menstruation*[212] Delaney et al. (1976) encourage women to embrace and take pride in their unique identity or differences. They urge society to break the habit of awkwardly avoiding discussions about menstruation or resorting to subtle forms of mockery through 'red humor'[213]. Third phase of a woman's lifetime process, menopause, is seen as a signal of aging and the end of reproductive ability and seen as the end of sexuality by the androcentric cultural and social norms. As a woman's societal standing is closely linked to her body and reproductive functions, the cultural attitudes towards menstruation and menopause extend to influence how womanhood itself is perceived (Lorber and Moore, 2002a, 2002b). For instance, women aged 40 and above in Turkey show pessimistic views about menopause, with their main premenopausal concern focusing on post-menopausal sexuality (Kısa et al., 2012). In

[212] The book is groundbreaking in many respects about the cultural taboos related to menstruation. The book is a comprehensive collection on the issue with detailed analysis from various areas. Some of the chapters are as follows: "The first pollution: Psychoanalysis and the menarche" and" The storm before the calm: The premenstrual syndrome" (Delaney et al., 1976, pp.64-72, 72-93).

[213] "Red humor," is a menstrual joke which is explained in the book chapter: "The Menstruating Woman in the Popular Imagination". The chapter explores how society perceives and represents menstruation within cultural narratives, folklore, and popular culture; in addition, it discusses the various ways in which menstruation is portrayed, including through humor or jokes, and how these representations contribute to societal attitudes and perceptions about menstruating women. "Red humor" refers to a type of humor or joke that revolves around the topic of menstruation. It is a term used to describe jokes, anecdotes, or cultural references that center on the menstrual cycle. See Delaney et al. (1976). It is important to note that while humor can serve as a tool to bring attention to and normalize discussions about menstruation, it is crucial to approach these representations with sensitivity, ensuring that they do not reinforce stigmatization or disrespect towards women's bodily experiences.

this chapter, I am going to consider menstruation management, menstrual-related conditions and stigma around it with a focus on the normalization of menstrual pain.

5.1. Menstrual Related Conditions and Normalization of Menstrual Pain

> "Rather than women using technologies to alter themselves to more comfortably fit the demands of a patriarchally shaped world, I would prefer to reshape the world to better accommodate women" (Aengst & Layne, 2013, p.185)[214]

Menstrual cycle related conditions have occupied a certain place in the literature however this phenomenon has always been difficult to put under a certain frame not only by medical practitioners but also by social scientists. Menstrual cycle related conditions of women can be listed as such: PMS, PCOS, menstrual pain (dysmenorrhea), endometriosis[215], irregular menstruation, pelvic pain, amenorrhea (loss of menstruation for several months), secondary amenorrheae[216], early menopause. For this study, I have not narrowed it down to one of the specific symptoms because they are all related to menstrual conditions and menstrual pain is common in all those menstruation-related health conditions.

All respondents indicated they experienced menstrual pain, while some have severe pains for long years (as in the case of Gönül, 52; Şükran, 50; Nüzhet,39; and Türkan,

[214] This excerpt is taken from Need to Bleed, in which Aengst and Layne (2013) expressed opposition to the use of menstrual-suppressing drugs, noting the societal influence on what is considered "normal" menstruation. They identify as a radical feminist and advocate for reshaping society to better accommodate women instead of women altering themselves to fit patriarchal norms. In simpler terms, I agree with their perspective that instead of women using drugs to suppress their periods to fit into a male-dominated world, modern society should change to better suit women's needs. Therefore, menstrual -related conditions and possible solutions to these conditions are considered within this paradigm in this thesis. Additionally, as a medical anthropologist in the era of "big pharma" (Angell 2005), Aengst is oriented against the expansion of drug regimens (2013, p.185). As being critical of the pharmaceutical industry, they also prefer non-drug options for managing menstruation due to concerns about the pharmaceutical industry's influence. For example, they prefer non-drug solutions such as menstrual cups, diaphragms, and reusable cloth pads Aengst & Layne, 2013, p.185).For more details about the "big pharma" See: Angell, M. (2005). The truth about the drug companies: How they deceive us and what to do about it. Random House.

[215] When endometrial glands and stroma are found outside of the uterus, it is known as endometriosis. Although the prevalence in teenagers is unknown, it has been calculated to be 6–10% of women of reproductive age.

[216] Lifelong absence of menses, known as primary amenorrhea, necessitates evaluation if menarche has not occurred by the age of 15 or three years after the development of secondary sexual characteristics (Klein et al., 2019).

37), some have moderate menstrual pain or back pain before or during menstruation which they had thought was “normal” to experience, causing them not to seek for healing about their pain. The accounts of women were notable. Several indicated at the beginning of our interview that they did not encounter difficulties with menstruation and considered their menstrual cycle to be regular, for example the case of Leyla and Pakize. However, as the interview progressed, they disclosed experiencing symptoms such as PMS, back pain prior to menstruation, pelvic pain, and a decreased appetite. It seems that when discussing health issues, they did not initially think to mention menstrual pain. In fact, when asked if they had experienced menstrual problems, they initially said no. Yet, as they shared more details about their experiences during the interview, they eventually revealed that their menstrual periods were indeed painful. The level of menstrual pain experienced by the interlocutors is shown in the table below.

Table 9. Interlocutors’ Level of Menstrual Pain

Level of Menstrual Pain	Interlocutors’ Name, Age	TCAM use & relief
Severe	Gönül,52; Şükran, 50; Nüzhet, 39; Hyrünnisa 37; Hicran, 38; Nuran, 61; Tijen, 45; Afet, 45; Türkan,37; Cahide, 43; Dilhan, 39	Yes
Moderate	Aysel, 40; Safiye, 39; Pakize, 42; Emine, 41; Leyla; 43	Yes
Low and time to time	Jale,43; Nermin 46	No change

Menstrual pain is often regarded as ‘normal’ by doctors, society, and women themselves, and it is generally considered a routine part of life. This normalization and trivialization occur in three domains as from medical authorities such as gynecologists and doctors; the environment as family and friends; and the self-negation on the side of women themselves ignore the severity. Firstly, the field results suggest that some of the respondents’ experience reflects the medical authority’s ‘normalization’ of menstrual pain. Gönül, Nüzhet, Şükran, Hayrünnisa,

Türkan, Cahide, and Dilhan began experiencing pain during their menstrual periods in early adolescence. They have been in search of treatment for an average of 7-10 years but have not been able to convince their doctors that their pain is "excessive" (Türkan, 37) or "unbearable" (Şükran, 50; Nüzhet, 39; Cahide, 43) or "It is not like what other girls experience" (Dilhan, 39). After receiving the response from doctors that their pain is normal, they were prescribed birth control pills and pain relievers to manage symptoms.

In these cases, the women are aware that their pain is too severe to be normal, but they are unable to convince either their families or their doctors that they are experiencing severe pain. They continue to live with recurring pain. Among these interlocutors, Nüzhet, Cahide, Safiye and Dilhan received a diagnosis of endometriosis after an average of 10 years. After initially being misdiagnosed with conditions such as appendicitis, they were eventually correctly diagnosed with endometriosis. Among these interlocutors, Türkan, Hayrünnisa, Şükran, Tijen were diagnosed with PCOS after an average of 7-10 years. Although they had many symptoms of PCOS and health risks associated with PCOS are serious such as Type 2 diabetes, high blood pressure, cholesterol abnormalities, sleep apnea, depression and anxiety, these women's menstrual pain did not see as an important sign to take detailed consideration by the doctors they consulted. It was revealed that diagnosis and treatment of health problems experienced by women were postponed as a result of ignoring menstrual pain.

Secondly, some of the interlocutors indicate that they accustomed to the pain themselves, so they perceive it as 'normal'. Despite experiencing painful menstruation, Pakize, Filiz and Aysel did not view this matter as significant and refrained from informing their physician about it for an extended period of time. Consequently, they did not seek medical attention for this issue and instead regarded the discomfort they endured as an inherent aspect of the menstrual cycle. It was only when they encountered challenges conceiving and began prioritizing the health of their uterus and ovaries to facilitate a successful pregnancy free of miscarriage that they turned their attention to addressing these concerns. Following childbirth, the severity of menstrual pain notably declined as a result of the alternative and

complementary treatment modalities they implemented targeting hormonal imbalances and ovarian dysfunction. In a similar way, Nuran and Afet did not view their menstrual pain as significant and refrained from informing their physician about it for an extended period of time. Due to the early menopause symptoms, they decided to consult the gynecologists about their menstrual cycle-related health. During our interviews, both of them indicated that they had not been aware of whether they had healthy menstruation or not.

In this chapter, I argue that the normalization and trivialization of menstrual pain by medical authorities, families, and women themselves leads to significant delays in diagnosing serious health conditions and inadequate treatment for conditions such as endometriosis and PCOS. As seen in the experiences of the women interviewed, this normalization contributes to years of unnecessary suffering and postpones proper treatment, underscoring the need for more attention to menstrual pain as a critical indicator of women's reproductive health.

5.1.1. The Importance of Recognizing and Addressing Pain and its Prevalence

Menstrual pain is characterized by periodic cramps and pain originating from the uterus during the menstrual period. Menstrual pain, also known as dysmenorrhea, is defined as a disease by the International Classification of Diseases (ICD-10)[217] of the WHO (Park et al., 2022). According to the International Association for the Study of Pain (IASP) Taxonomy Working Group "Dysmenorrhea is characterized by abdominal or pelvic pain occurring just before or during menstruation" (2011). There are two types of classification of menstrual pain as primary and secondary. Primary Dysmenorrhea (PD) is described pain during menstruation without any organic

[217] Definition of Menstrual Pain by ICD-10. It is under the number of ICD-10 code N94.4. The name of the code title is Pain and other conditions associated with female genital organs and menstrual cycle N94. Some of the related codes are as such:
N94.3 Premenstrual tension syndrome
N94.4 Primary dysmenorrhea
N94.5 Secondary dysmenorrhea
N94.6 Dysmenorrhea, unspecified
Information taken from: https://www.icd10data.com/ICD10CM/Codes/N00-N99/N80-N98/N94-
For the list of ICD-10 - code of "Pain and other conditions associated with female genital organs and menstrual cycle" see APPENDIX F.

pathology (Sachedina and Todd, 2020; De Sanctis et al., 2015). Secondary dysmenorrhea, on the other hand, is menstrual pain in the presence of pelvic pathology or due to recognized medical conditions like endometriosis and adenomyosis in premenopausal women (Sachedina and Todd, 2020, p.7). There is no single and unchangeable definition for menstrual pain partly because the concept of 'pain' also does not have a single fixed definition. It has been revised with new studies. According to the IASP, classification of chronic pain was originally published in 1986, with a second edition published in 1994. Updates were made to selected sections in 2011 and 2012, including the pain definitions (terminology). The 1979 version of the definition relied upon an individual's ability to describe the experience to qualify as pain. The old (1979) definition is: "An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage"[218]. This definition of pain was revised to "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage". The revised definition and notes were unanimously accepted by the IASP Council[219] by the Taxonomy Working Group (Raja et al, 2020).

The accounts of women about their menstrual pain are as such:

> I always had pains. I always had such heavy, painful periods. I mean, I was constantly a person suffering from pain. That, you know, I got married and all, after we got married, we wanted a child and of course it didn't happen. That process started like that.[220] Cahide

> I am very bad, I'm dying from weakness. My intestines are sometimes good, sometimes bad, but I can say this, my periods were going terribly.[221] Dilhan

218 https://www.iasp-pain.org/resources/terminology/

219 The book is available as a soft copy since the content is regularly updated by IASP's pain experts. In support of IASP's educational mission, the contents will be freely available for download from this website." https://www.iasp-pain.org/publications/free-ebooks/classification-of-chronic-pain-second-edition-revised/

220 Benim hep ağrılarım oldu. Hep böyle ağır ağrılı dönemlerim vardı. Yani sürekli ben ağrı çeken bir insandım. Onu, işte evlendim falan, evlendikten sonra bir çocuk isteğimiz oldu ve tabii ki bir türlü olmuyor. O süreç öyle başladı. Cahide

221 Çok fenayım, halsizlikten geberiyorum. Bağırsaklarım bir iyi bir kötü ama şunu söyleyebilirim, adetlerim korkunç geçiyordu. Dilhan

> When I had my first period, it was painful. I had to lie in bed. They used to heat the towel and put it on my stomach. In fact, my aunt used to heat a brick on the stove during her girlhood and put it under her feet. I put a hot water bottle. I still use it. The feeling of cold doesn't go away. But the worst is the cramp pain. ... Once I was alone at home, I was in my mid-20s. I felt like I was going to faint, I called my friend, I fainted until she came.[222] Türkan

> My main complaint was always these pains. They took me to the hospital every 2-3 months. They said some of them were due to polycystic ovaries. They suspected appendicitis. They suspected Mediterranean fever. They prescribed medications. They even diagnosed me with a stomach-intestinal infection. I used antibiotics unnecessarily. Finally, after 1.5 years, my appendix burst. and they said retroactively, "oh, it was appendicitis.[223] Nüzhet

These accounts highlight the persistent nature of menstrual pain experienced by women, often ignored or misdiagnosed by medical professionals. Despite their suffering, their pain was frequently normalized or attributed to other conditions, leading to delayed or inadequate treatment. Firstly, I will address the prevalence of the issue, emphasizing the need for its recognition. The most prevalent gynecological issue experienced by women in their reproductive years is menstrual pain (Iacovides et al., 2015; Coco, 1999). Between 45% and 95% of women of reproductive age experience menstrual pain, almost equating to over 855 million women worldwide (Gagnon et al., 2022; Chen et al., 2017; Iacovides et al., 2015; Avidon & Baker, 2015; United Nations Department of Economic and Social Affairs Population Division, 2015).

The vast majority, ranging from 70% to 93% of female adolescents' experience discomfort related to menstruation (Sachedina and Todd, 2020, p.7). Moreover, Gokyildiz et al. (2014) and Ballard et al. (2006) summarizes the epidemiological research that indicate a significant prevalence of chronic pelvic pain among women

[222] İlk regl olduğum zamanda ağrılı olmuştu. yatakta yatmam gerekiyordu. havluyu ütüleyerek ısıtıp karnıma koyuyorlardı. hatta, teyzem genç kızlığında tuğlayı sobada ısıtıp ayak altına koyarmış. sıcak su torbası koyuyordum. hala da kullanıyorum. üşüme hissi geçmiyor. ama en ağırı kramp ağrısı. …. bir kez evde tekim 25 yaşlarındaydım. bayılacak gibi oldum, arkadaşımı aradım, gelinceye kadar bayılmışım. Türkan

[223] Benim temelde en önemli şikayetim bu sancılardı. 2-3 ayda bir beni hastaneye götüren. onların bir kısmının polikistik over'den kaynaklandığını söylediler. apandistten şüphelendiler. akdeniz ateşinden şüphelendiler. ilaçlar yazıldı. mide- bağırsak enfeksiyonu teşhisi bile konuldu. antibiyotikler falan kullandım gereksiz gereksiz.en sonunda 1,5 sene sonunda apandistim patladı. ve "aaa apandistmiş" dediler geriye dönük olarak Nüzhet

in their reproductive years, ranging between 13,8% in America (Mathias et al., 1996); 3,8% in Great Britain (Zondervan et al., 2001); 25,4% in New Zealand (Grace and Zondervan, 2004); and 26,6% in Egypt (Muhammad et al., 2011). Gokyildiz et al., (2014) indicate that research demonstrates a substantial prevalence of chronic pelvic pain (CPP) among women (p. 144). However they did not provide a result that was obtained from research conducted in Türkiye, the data-based research has been predominantly coming from the UK, USA, and New Zealand. Similarly, as Polat et al. (2008) claim the prevalence of menstrual pain in Türkiye is not measured. They posit, "Unfortunately, both the prevalence of menstrual pain and the manner in which females attempt to solve this problem are unknown in most of the developing countries" (Polat et al., 2008, p. 527). Their survey-based study is the first of its kind in the context of Türkiye, delved into the prevalence of primary dysmenorrhea among young female university students. Examining 1,266 participants, they discovered an overall prevalence of menstrual pain at 88.0%, with 45.3% experiencing pain during every menstrual cycle, while the remainder experienced it intermittently (p.531). While their research did not extend to the broader population, it serves as a noteworthy representation of the Turkish scenario at that time.

A recent survey conducted in 2023 marked the first significant attempt to assess the frequency of endometriosis in Türkiye, drawing high participation. According to this study, based on self-reported information, it was found that approximately one out of every six women of reproductive age[224] in Turkey has been diagnosed with endometriosis (Yuksel Ozgor et al., 2023). Some studies have looked at biological, socio-demographic, and nutritional factors and female students' dysmenorrhea experiences and practices for coping with pain, (such as Şentürk Erenel A, & Şentürk, 2007; Eryilmaz et al., 2010; Potur et al., 2914; Yılmaz et al., 2020; Doğan et al., 2019), effects of menstrual pain on the academic performance (Orhan et al., 2018), environmental factors and social effects of the causes of menstrual pain (for example, in Şahin et al., 2014), complementary treatments offered (Yaşar et al., 2020). The presence of marital status, stressful close relationships, lack of social

[224] Turkish women's percentage is higher when compared to other regions. Research conducted across various geographical regions indicates that approximately one out of every 7 to 10 women receives a diagnosis of endometriosis (Yuksel Ozgor et al., 2023).

support, and the presence of individuals with dysmenorrhea in the close vicinity have been identified in some studies as variables affecting dysmenorrhea (Eser & Kaya, 2023). These studies largely lack a theoretical perspective, and they are descriptive.

5.1.2. The Hidden Epidemic: Under-Diagnosis of Menstrual Pain

Although the prevalence is very high, it is claimed that not sufficient and necessary importance have been given to menstrual pain. In the first place, the approach of the health care practitioners and pain researchers to the menstrual pain is inadequate in the sense that even though it is frequently observed among women of reproductive age, it tends to be overlooked and inadequately addressed (Iacovides et al., 2015, p. 762). It is argued that it is under-diagnosed and lacks proper treatment (Iacovides et al., 2015; Markovic et al., 2008; Campbell and McGrath, 1997; Coco, 1999; Proctor and Farquhar, 2006; Sobczyk, 1980). A more recent study by Gagnon et al. (2022) also confirms this condition as indicating dysmenorrhea has been largely overlooked compared to other pain conditions. Moreover, Gagnon et al.'s study lays stress on pain under the part of women's health issues and claims that like various other women's health issues, menstrual pain has often been disregarded and not given adequate treatment (Gagnon et al., 2022). As expressed by the participants in this fieldwork, the doctors whom the women consulted did not provide sufficient attention or treatment recommendations.

> These pains gradually increased. I was going to the doctor. I say it hurts a lot. "You will take painkillers, it's normal," he says. But I say it hurts so much, I vomit sometimes. So many cramps in my stomach. I wonder if this is normal? "Well, you have PCOS, it's normal for it to hurt," he says.[225] Nüzhet

Türkan's account is:

> For years, I spent my periods with painkillers. and I still can't believe it. I've been having my period without taking majesics for the last 3-4 years, and it felt like a miracle during the first menstrual periods I experienced. Just last summer, on my first period, I walked comfortably to a yoga class. "This is miracle" on the way, I said. I'm on my period today, I'm leaving the house,

[225] Bu ağrılar giderek arttı. doktora gidiyordum. çok ağrıyor diyorum. "ağrı kesici alacaksın normal" diyor. ama çok ağrıyor diyorum, kusuyorum bazen. o kadar kramplar giriyor karnıma yani. bu kadar normal mi diyorum. "eee pcos'un var ağrıması normal" diyor. Nüzhet

> I'm walking. So would people be happy about this? How happy I was when I left. Because it wouldn't be normal for me on the first day. I was literally crawling. Since I was 15 years old, doctors tried to make me addicted to magic. When I think of those doctors, I get very angry. How could they be so blind and insensitive? They didn't care. It was as if I was exaggerating in their eyes. No, I wasn't exaggerating, the pain was unbearable. Take Majezik!! (gets angry). Especially male doctors, I don't think they understood at all.[226] Türkan

This tendency to ignore pain is also evident among women themselves. Dysmenorrhea is often overlooked not only by healthcare providers and pain researchers but also by the women experiencing it.

> The women's approach (referring to the women around her social environment) was no different from that of the doctors. They considered it normal to have pain. Haaa, with old lady methods like put stones, keep warm, keep your feet warm...suggestions. so no one understood my thing. So they couldn't understand that it was a killing pain.[227] Safiye

Because of this widespread tendency to downplay menstrual pain, many women are unfamiliar with the term 'dysmenorrhea' as a vivid observation from the fieldwork. Many women in my interactions during the participant observation and women with whom I had conversations that were not in interview format also have a tendency to ignore their menstrual pain, although they have reproductive health issues. Even if they experience pain, they often do not perceive it as a significant issue worth mentioning.

This narrow perspective on reality poses challenges for bodies with complex pain factors, such as menstrual pain resulting from the convergence of multiple organ

[226] Yıllarca ben ağrı kesiciler ile geçirdim regl günlerimi. ve buna hala inanamıyorum. son 3-4 yıldır majezik içmeden regl oluyorum ve bunu ilk yaşadığım regl dönemlerinde mucize gibi geliyordu. daha geçen yaz, ilk regl günümde rahat bir şekilde yürüyerek yoga dersine gidiyorum. Yolda, dedim: "bu mucize". Ben bugün regl oluyorum, evden çıkışım, yürüyorum. Yani insan buna sevinir mi? giderken nasıl mutlu olmuştum. Çünkü benim öyle normal olmazdı ilk gün. Sürünüyordum resmen. 15 yaşımdan itbaren doktorlar beni majezik bağımlısı yapmaya çalıştılar. o doktorlar aklıma geldikçe çok sinirleniyorum. nasıl bu kadar kör ve duyarsız olabildiler. önemsemediler. sanki ben abartıyordum onların gözünde. Hayır, abartmıyordum, dayanılmaz ağrılar oluyordu. Majezik iç!! (sinirleniyor). hele erkek doktorlar hiç anlamıyordu bence. Türkan

[227] Kadınların (sosyal çevresindeki arkadaşlarını kastediyor) yaklaşımı da doktorlarınkinden farklı değildi. normal kabul ediyorlardı ağrı olmasını. haaa, taş koy, sıcak tut, ayağını sıcak tut gibi koca karı yöntemleri ile... tavsiyeler. yani kimse benim şeyimi anlamadı. öldürücü bir ağrı olduğunu anlayamadılar yani. Safiye

systems in the pelvic region. These bodies struggle to fit within the confines of the existing medical model. As a result, women who are experiencing pain most of the time go undiagnosed, untreated, and left bewildered about the reasons behind their suffering. This systemic failure to properly assess and address the pain in women patients reflects a deeper issue within the medical system that prioritizes standardized, objective measures, lived experiences of patients.

During my in-depth interviews and off-the-record conversations with women of various ages, ethnic backgrounds, and social and cultural statuses, it became clear that women experiencing menstrual pain often minimized their discomfort. Initially, they would say, “my pain isn't that significant,” but as they continued to describe their experiences, it became evident that they were dealing with severe cramps and significant disruptions to their daily lives. Yet, when first asked, they claimed they had no problems with menstruation. Menstrual problems and pain have been so normalized that even those experiencing severe discomfort try to endure it as much as possible.

Many women with primary dysmenorrhea neglect to mention their ailment in medical interviews because it is so frequent (Coco, 1999). Even though the everyday activities of women are restricted and affected because of the pain and other symptoms, they do not even disclose it to doctors. These women are in a state of habit that they do not see the need to point out the issue because they experience it so frequently.

Another reason for the neglect is because menstrual pain may be perceived as a typical aspect of the menstrual cycle (Iacovides et al., 2015, p. 762) which causes women to overlook pain. As I underlined before, Coco (1999) indicated prevalence rates up to 90%, which is a very high rate. Given this significant portion, it might be assumed that women will seek medical attention from health practitioners with widespread interest and effort. However, statistics indicate otherwise. Therefore, another explanation to its under-diagnoses is that most women refrain from seeking medical care and help (Chen et al., 2017; Markovic et al., 2008; Proctor, 2006; Itani et al., 2022, p. 102).

At this point, it is relational to remember what Charmaz and Rosenfeld (2016) underlined, "Just as disease may be unrecognized and unfelt (see Conrad 1987, p.2), deeply disturbing symptoms may arise without being diagnosed as a disease, even in the absence of perceivable organic causes" (Cockerham et al., 2016, p.312). Disease can be unnoticed and upsetting symptoms can arise without being diagnosed as a disease. For menstrual-related conditions in women, specifically menstrual pain, a parallel explanation can be drawn. Moreover, the insights on chronic illness in Charmaz and Belgrave's (2015), article "Chronic Illness and Disability"[228], have some parallels with menstrual pain. Their main contribution is to distinguish between 'chronic illnesses' and 'disease'. Living with a chronic illness presents challenges such as adhering to treatment plans, managing daily responsibilities, and facing social stigma. In contrast, a disease can remain asymptomatic for an extended period, causing minimal disruptions. The experience of chronic illness brings the reality of the disease to the forefront (Charmaz & Belgrave, 2015). Early sociological studies by Roth, Goffman, and Davis marked the emergence of chronic illness as a field of inquiry. According to Charmaz and Belgrave (2015), these studies contrasted with Parsons's concept of 'Sick Role', since 'Sick Role' is assumed recovery (at one point), successful medical intervention and passivity in patients. However, in the case of repeatedly recurring symptoms, like chronic pain these three assumptions do not work as Parsons argued (Charmaz & Belgrave, 2015). Consequently, menstrual pain requires ongoing management as symptoms persist and repeat. Most of the time, the biomedical approach leads to a focus on treating symptoms and preventing complications. In the table below we can see possible cause of secondary dysmenorrhea. The table helps in identifying and understanding the various potential causes of secondary dysmenorrhea, distinguishing between those originating from within the uterus and those from outside the uterus. This categorization may provide how the diagnosing and developing appropriate treatment plans for women experiencing menstrual pain can be challenging.

228 They highlight the challenges faced by individuals with chronic illnesses. It emphasizes how chronic illness can impact various aspects of life, such as following medical regimens, managing daily responsibilities, and dealing with stigma. The article sheds light on the complexities and difficulties that individuals living with chronic illnesses encounter, emphasizing the need for a deeper understanding of the patients' experiences.

Table 10. Information From Smith RP. Gynecology in Primary Care. Baltimore: Williams & Wilkins, 1997:389–404. Taken from : Coco A. S. (1999). Primary dysmenorrhea. American family physician, 60(2), 489–496.

Possible Causes of Secondary Dysmenorrhea	
Uterine causes	*Extrauterine causes*
Adenomyosis	Endometriosis
Pelvic inflammatory disease	Inflammation and scarring (adhesions)
Cervical stenosis and polyps	Functional ovarian cysts
Fibroids (intracavitary or intramural)	Benign or malignant tumors of ovary, bowel or bladder, or other site
Intrauterine contraceptive devices	Inflammatory bowel disease

It is not uncommon for some symptoms to remain undiagnosed. For example, musculoskeletal pain is one among them. Johansson et al. (1999) conducted a grounded study to explore musculoskeletal pain which remained without diagnoses. The study explores the experiences of female patients with pain that is not defined in biomedical terms. The significant result is that the patients' suffering is invisible. Similarly, Emma Whelan's article 'No one agrees except for those of us who have it': endometriosis patients as an epistemological community" focuses on the invisibility of the pain of endometriosis, which is directly related to pelvic and menstrual pain. For many chronic illnesses, the suffering is invisible (Barker, 2005; Charmaz 2000; Werner & Malterud 2003; Grace, 1995). As shown by Whelan, in the case of endometriosis patients, the pain resulting from endometriosis is invisible and often dismissed by society and doctors (Matías-González et al., 2022; Whelan, 2007, p. 960). This brings into question why certain types of pain remain invisible and what factors contribute to their under-diagnosis.

The lack of interest both from the healthcare practitioners and from women themselves stems partly from the normalization of menstrual pain due to the perception of menstrual pain as something women should endure. For instance, some researchers attribute the reason for normalization of menstrual pain to the overuse of anti-inflammatory medication. As Markovic et al. (2008) posits, "The wide availability of over-the-counter anti-inflammatory medication specifying suitability

for short-term relief from period pain reinforces the notion that 'all' women experience pain and therefore that such pain is 'normal'" (p.350). This implies that pain is expected, and the symptoms can be easily reduced by anti-inflammatory medication.[229] Therefore, the pain women feel is often considered 'normal' and is seen as a natural part of the menstrual process.

> Tijen: I had gone to the doctor for other complaints as well. To have my thyroid checked. Or for my blood sugar... I had been diagnosed with reactive hypoglycemia. So I was seeing the doctor for that too. During that time, they would ask me, "Do you have painful periods?" and I would say yes. I would also bring it up, saying, "By the way, my periods are really painful, so keep that in mind," but they didn't really take it seriously. Because once they saw I had PCOS, they'd say, "Ah, okay, this is PCOS, so there is no need to look into it further." Well, okay, then fix it. (She gets frustrated here.) They don't think about fixing it. When they see PCOS and pain together, for them, that's normal. The solution, for them, is Majazik (a painkiller).
>
> I: So it is like, "As long as you have pain, we will just give you a painkiller"?
>
> Tijen: Yes. That's exactly what the doctor said. And I told the doctor, "But my body is telling me that this pain is not at a normal level. There's something wrong here. Please, okay, fine, I'll take the painkillers. But can you explain to me what's causing this pain?" And the response was, "Well, you have polycystic ovaries." Okay, but why? How will this be resolved? "It's normal. It happens these days. It will go away once you give birth." That's pretty much it.
>
> I: Did you hear this more than once?
>
> Tijen: Yes, of course, of course. Four or five times, at least. Some women around me were also suffering from pain, and they would just take painkillers and sit down.[230]

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[229] Even though some clinical studies on menstrual pain treatment mention the existence of alternative methods to anti-inflammatory medication, what is tried to be treated is still within the limits of the symptoms. For example, in the study of Akduman and Budur (2016), acupuncture, Transcutaneous Electrical Nerve Stimulation (TENS) and heat application are listed as recommended methods instead of the painkiller ibuprofen. Alternative therapies heat, thiamine, magnesium, and vitamin E are said to be effective. Even this demonstrates that pain experience is regarded as "normal".

[230] Tijen: başka şikayetler için de doktora gitmiştim. tiroid ölçtürmek için. veya şeker... bende reaktif hipoglisemi teşhisi konmuştu . onun için falan da doktora gittiğim için. o dönem de soruyorlardı, reglerin ağrılı geçiyor mu falan. evet diyordum. onlara da soruyordum. başka sebeplerden de gidiyordum, bunu da söylüyordum. reglerim de çok ağrılı geçiyor onu da dikkate alın ha, diye söylüyordum ama onu pek dikkate almıyorlardı. çünkü pcos'u görünce "haaaaa, ok, bu pcos. o zaman ona bakmamıza gerek yok " diyorlar. iyi ama çöz o zaman. (sinirleniyor burada) çözümü düşünmüyor. pcos ve ağrıyı bir arada gördüğü zaman bu onun için normal. çözümü majazik onun için
Ben: Ağrı oldukça ağrı kesici vericez sana, gibi mi?

Tijen's account highlights the normalization and dismissal of women's menstrual pain in medical encounters. Her frustration reflects a broader issue of how women's pain, particularly related to reproductive health, is often minimized or attributed to common conditions like PCOS, without further exploration or attempts to address the root cause. The doctor's response to Tijen with the expectation that childbirth will resolve the issue, reflects a paternalistic approach that fails to validate the patient's subjective experience.

This case emphasizes how medicalization, the framing of health issues as biological and solvable with medical interventions, fails to address the complexities of women's lived experiences, particularly when social and psychological dimensions of pain are overlooked. For example,the reliance on childbirth as a "solution" also reinforces traditional gender roles, suggesting that reproductive functions can solve medical problems rather than focusing on comprehensive health care.

Tijen's experience can be interpreted as a form of epistemic injustice (Fricker, 2017), particularly *testimonial injustice*[231] (Arcila-Valenzuela & Páez, 2022). Tijen's account of her pain is not taken seriously because of preconceived medical beliefs that menstrual pain and PCOS are "normal" and inevitable for women. This leads to a reductionist approach where complex symptoms are reduced to standard or inadequate treatments, like prescribing painkillers without addressing underlying issues. Additionally, her story reflects the broader cultural phenomenon of gendered medical neglect, where women's experiences, particularly with reproductive health,

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Tijen: evet. doktorun söylediği bu. ve ben doktora dedim ki "ama vücudum bana bu ağrının normal bir seviyede olmadığını söylüyor yani. burda bir anormallik var. "lütfen ama. ağrı kesici tamam eyvallah. ağrı kesici içelim. ama bunun bana bi sebebini anlatır mısınız?" dediğim zaman. cevap "işte polikistik over'sın sen". Peki o neden, nasıl çözülecek? "normal işte. günümüzde oluyor. doğurunca geçer". falan yani bu.
Ben: bunu 1 kereden fazla mı duydun?
Tijen: evet tabi tabi. 4 -5 kez. en az. çevremdeki bazı kadınlar da ağrı çekiyordu. ve ağrı kesici alıp oturuyorlardı.

[231] Testimonial injustice refers to an unjust credibility deficit assigned to a speaker due to the hearer's identity prejudice. This prejudice, whether consciously or unconsciously held, results in the speaker's knowledge being unfairly devalued in testimonial exchanges. The article emphasizes that while it is difficult to identify singular instances of testimonial injustice due to the subtlety of ingrained biases, broader patterns can reveal consistent behavioral tendencies of prejudice (Arcila-Valenzuela & Páez, 2022).The widespread history of racism and sexism across various societies globally provides ample evidence to support the idea that testimonial injustice is a frequent occurrence (p. 586).

are trivialized, perpetuating a cycle where their pain is normalized rather than treated comprehensively.

The second reason for the normalization of menstrual pain is the topic of pain management within the biomedical framework. “Part of the problem in pain management is that scientific medicine has reduced the experience of pain to ‘an elaborate broadcasting system of signals, rather than seeing it as molded and shaped by the individual and their particular socio-cultural context’” (Bendelow and Williams, 1995; as cited in Johansson et al., 1999, p. 1791). Therefore, the normalization of menstrual pain is a consequence of the scientific medicine’s tendency to view pain as signals, rather than considering how pain is influenced by the unique experiences and cultural factors of the person[232].

Normalization of menstrual pain occurs both in biomedical context as well as social context. As Markovic et al. (2008) and Ito and Pascual (2024) argue that women with endometriosis endure their pain in the early stages and in many cases it takes for years for women to disclose it (Whelan, 2007) and women avoid seeking medical care for many years because of this normalization. Therefore, socio-cultural meaning attribution to menstruation affects a woman’s perception of their pain. The normalization of the pain raises a pressing concern, as society’s normalization of their pain can have serious ramifications:

> It leads doctors to send patients home, but on the other hand, it also forces patients to endure pain. Following this discursive line of argument, the patient seems to be expected to embrace the symptoms and get along with them without complaining. This is not only insensitive but also abusive on the part of any society. (Ito & Pascual, 2024, p.6)

232 “Health and illness are socially constructed notions which mean different things to different people. When there are discrepancies between diseases and illness behavior there are disputes both among lay and professionally trained people. Eccleston et al. found that patients contest the reality of the pain and its physical origin, while physicians tend to see chronic pain as a dysfunctional reaction (Eccleston et al., 1997). In society the notion of the biophysical facts has primacy over humanistic interpretations. This false dichotomy of soul and body has a great impact on the misunderstanding and mistrust uncovered in our study. One woman said: ``I was stressed, but I didn't talk about that with the doctor, he might have considered me a psycho" (cleaner, 34 yr.). This dualism permeates not only lay beliefs but also, as described in the introduction, physician's beliefs, politicians and the legislation” (Johansson et al., p. 1798).

The literature on the subject suggests that women are seemingly required to accept their symptoms without voicing any complaints. Ito and Pascual argue that such expectations placed on patients not only lack sensitivity but may also be perceived as a form of mistreatment.

For example, from the interlocutors' accounts, Safiye, indicates that:

> When I was in university, I was around 20 or so. At that time, I did not know my problems were related to women's health. I would just go to the hospital once a month or every two months with unbearable abdominal cramps. This process continued for about 1-2 years, 3 years actually. I would experience random abdominal cramps every 1-2 months, without being able to predict when they would happen. Every time I went to the hospital, the doctors would give me an IV and make diagnoses. Many incorrect diagnoses were made. They even mentioned Mediterranean fever. Eventually, after those 2-3 years, they looked at it with an ultrasound and said I had polycystic ovary syndrome.[233] Safiye

Safiye's experience presents a significant issue within the healthcare system: the tendency of doctors to dismiss symptoms and send patients home without thorough investigation. Her account can be conceptualized as a reflection of both biomedical shortcomings and the broader critique of how women's health issues are often overlooked or misdiagnosed within conventional healthcare systems.

Her story underscores the issue of misdiagnosis, a recurring theme in critiques of biomedicine, especially in women's reproductive health. The fact that she received multiple incorrect diagnoses and it took years before the identification of PCOS reveals a gap in the biomedical model's ability to address complex, hormonal-driven, health issues in women. This tendency forces patients to endure prolonged pain and leads to delayed diagnoses. In her case, recurrent and severe abdominal cramps were met with temporary solutions such as IV treatments and inaccurate

[233] Üniversitede. 1-2 civarında. o zaman aslında sorunlarımın kadın sağlığından olduğunu bilmiyordum. sadece böyle ayda bir, iki ayda 1, çok dayanılmaz karın krampları ile hastaneye gidiyordum o zaman. yani bu 1-2 sene 3 sene devam etti bu süreç. 1-2 ayda bir random bir şekilde , ne zaman olacağını tahmin edemeyeceğim bir şekilde karın krampları yaşıyordum. doktorlar her hastaneye gittiğimde serum veriyorlar. teşhisler koyuyorlar falan.yalan yanlış bir sürü teşhis kondu. akdeniz ateşi bile dendi… eninde sonuda , o 2-3 senenin sonunda ultrason ile bakıp, polikistik over var dediler. Safiye

diagnoses, rather than a deeper exploration of the underlying cause. This pattern not only prolongs patient suffering but also delays the identification and management of conditions like PCOS, which Safiye was eventually diagnosed with after enduring random and unpredictable pain for 1-2 years. The delay in diagnosis and inadequate initial responses from medical professionals highlight a broader issue of insufficient attention to women's health concerns.

The biomedical approach, which tends to compartmentalize the body and treat symptoms in isolation as discussed in the Chapter 3.2., failed to view her symptoms holistically. Moreover, her experience also reflects the absence of personalized, patient-centered care in biomedicine. Biomedical treatments were reactive and impersonal, focused on relieving immediate symptoms rather than understanding her individual experience or exploring the emotional and psychological dimensions that might have been connected to her condition.

In contrast, holistic approaches encourage an understanding of health, considering the patient's entire physical, emotional, and social context. The fact that it took years to diagnose PCOS could be seen as a failure to acknowledge and incorporate the lived, cyclical experiences of women's bodies as discussed in the Chapter 4. There is a recognition that conditions like PCOS affect not only the physical body but also mental well-being. In sum, her narrative illustrates a critique of biomedicine's limitations, particularly in women's health, where symptoms may be dismissed or poorly understood due to the focus on immediate, measurable interventions.

When we look at the prevalence and late diagnosis in Türkiye, a recent research shows that the average time for the diagnosis is four years; and the complaints during the menstrual period were underestimated. Yuksel Ozgor et al. (2023) indicates:

> According to 1820 (63.2%) participants with endometriosis, people did not believe their pain or symptoms. The average number of physician visits was four before diagnosis. The average duration from symptom onset and initial attendance visiting a clinician was eight months (IQR = 2-24 months). In patients with endometriosis, the average period between the initial hospital attendance and the diagnosis was four years (IQR = 1-5 years). Most participants with endometriosis (77.9%) experienced financial difficulties due

> to their therapy. A total of 1152 individuals with endometriosis reported work/school difficulties (28.3%), and 224 (7.4%) respondents could not attend class/work due to endometriosis-related symptoms. … The survey showed that the most common symptom that caused hospital attendance in the beginning was a complaint happening during the menstrual period, and persistent groin pain was the next most-common complaint. Painkillers were the most commonly used medical treatment for respondents with endometriosis (73.3%) (p.6).

Moreover, the normalization of pain may have consequences for the women's wellbeing. Avoiding medical care at the appropriate time can further delay the process of receiving a diagnosis. Women, in particular, face skepticism and dismissal of their symptoms, which results in a lack of appropriate care and support.[234] Many of the studies make a connection between the diagnostic delays and the normalization of menstrual pain in the case of endometriosis (Matías-González et al., 2022; Markovic et al. 2008; Whelan 2007; Ballard et al., 2006; Huntington and Gilmour 2005). Similarly, in the case of dysmenorrhea, "Due to normalization of dysmenorrhea, there is delay to diagnosis and treatment" (Sachedin & Todd, 2020, p. 9).

One of the interlocutors from the fieldwork summarized her delay in the treatment process as follows:

> They suspected appendicitis. They suspected Mediterranean fever. medications were prescribed. He was even diagnosed with a gastrointestinal infection. I used antibiotics etc. unnecessarily. Finally, after 1.5 years, my appendix burst. and they said retroactively, "oh, it was appendicitis."… modern medicine at that time could not give me anything - could not give me a solution. They removed my appendix after it burst, but beforehand, the pain was due to this or there was no treatment for those pains. After the appendectomy, I put it on hold in a sense, as if my health problems were gone. But since the pcos was there, I had very painful menstrual periods. Even though the university headache was not that painful, by the end of the university, I was drinking 1-2 majesics or 3 majesics throughout the entire semester. These pains gradually increased. I was going to the doctor. I say it

234 This scenario calls for a more empathetic and thorough approach to patient care, where doctors take the time to listen to and investigate their patients' symptoms comprehensively. In Chapter Two, Biopschosocial approach to health and illness and how this approach can function in the healthcare system is discussed in detail. Addressing this issue is crucial for improving patient outcomes and ensuring that individuals like Safiye receive the care they need without unnecessary suffering and prolonged uncertainty.

> hurts a lot. He says it's normal, you will take painkillers. But I say it hurts so much that I vomit sometimes. So many cramps in my stomach. I wonder if this is normal? "Well, you have PCOS, it is normal for it to hurt," he says. I wonder how it will go. "Well, the body gets cleaned after giving birth," she says. He says then it will pass.[235] Nüzhet

In Nüzhet's account, it is evident that her doctor was repeatedly trivialized her pain and concerns. Despite experiencing severe and debilitating symptoms, her reports of intense pain were often dismissed as "normal" with given reference to her PCOS diagnosis. Is it normal to have severe pains if a woman has PCOS? Even the pain is due to PCOS or not, should not the real question be how to solve this? The doctors' suggestions to merely take painkillers and their assertions that her pain would subside only after childbirth illustrate a dismissive attitude towards her suffering. This not only invalidated her experiences[236] but also left her without adequate treatment or solutions, highlighting a critical failure in her medical care. However, in the following years, it was diagnosed that Nüzhet's health problem was not limited to PCOS, but that she had endometriosis.

> Then I went to Italy with the choir. I couldn't find any food there. I quit the diet. Then I went back to painful periods. Then I lived like that for a while. After that something was detected. I was diagnosed with endometrioris after a while. 1-2 years later. If this is the diet I told you about in 2009, the endometriosis diagnosis may have been in 2011. When you are diagnosed with endo, go to the doctors again, it is still painful. They say it will go away once you get married again.[237] Nüzhet

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[235] Apandistten şüphelendiler. akdeniz ateşinden şüphelendiler. ilaçlar yazıldı. mide- bağırsak enfeksiyonu teşhisi bile konuldu. antibiyotikler falan kullandım gereksiz gereksiz. en sonunda 1,5 sene sonunda apandistim patladı. ve "aaa apandistmiş" dediler geriye dönük olarak.. … bana o dönemde modern tıp bana bir şey veremedi - bir çözüm veremedi. apandistim patladıktan sonra aldılar ama öncesinde ağrılar şu yüzdendi, ya da o ağrılara yönelik bir tedavi falan olmadı. apandist ameliyatı sonrası bir anlamında askıya almış oldum sanki sağlık problemlerim geçti gibi. ama pcos orada durduğu için çok ağrılı regli dönemleri yaşadım. üniversite başı o kadar ağrılı olmamasına rağmen üniversite sonunda artık her 1-2 majezik ,3 tane majezik içiyordum tüm period süresince. bu ağrılar giderek arttı. doktora gidiyordum. çok ağrıyor diyorum. ağrı kesici alacaksın normal diyor. ama çok ağrıyor diyorum kusuyorum bazen. o kadar kramplar giriyor karnıma yani. bu kadar normal mi diyorum. "ee pcos'un var ağrıması normal" diyor. nasıl geçecek diyorum. "ee doğurunca temizleniyor zaten vücut " diyor. o zaman geçer diyor. Nüzhet

[236] I discussed the subjective experience and lay perspective's importance in Chapher Two. 2.2.1.4. Undervaluation of the subjective experience of the patients.

[237] sonra İtalya'ya gittim koro ile. orada yiyecek bulamadım. diyeti bıraktım. sonra ağrılı regllere geri döndüm. sonra bir süre öyle yaşadım. ondan sonra şey tespit edildi. endometrioris teşhisi kondu bir süre sonra. 1-2 sene sonra. bu sana bahsettiğim diyet 2009 ise, endometriosis teşhisi 2011 olabilir.

The delay in diagnosis is so common that much of the research typically focuses on significant delays in diagnosing conditions like endometriosis (Wilson, 2021). "All painful symptoms related with endometriosis are poorly specific and patients need to consult many different specialists and face a long process before a specific diagnosis" (Centini et al., 2013, p.28). Delaying the diagnosis[238] and treatment of the patient can have negative effects on their health and overall well-being (Ito & Pascual, 2024). However, early diagnosis is important for the treatment and well being of women. Receiving a diagnosis can provide advantages such as better understanding and managing of one's health needs, and potentially gaining more support and accommodations in social and occupational settings. Moreover, diagnosis equips them with a structured framework for communicating their condition, facilitating more effective dialogue with healthcare professionals and peers. This enhanced communication fosters a greater sense of agency over symptom management, empowering individuals to actively participate in their treatment journey. Additionally, the confirmation that symptoms are not attributable to cancer provides reassurance and aids in cultivating a more positive outlook on health outcomes (Ballard et al., 2006).

Researchers have observed that menstrual pain in the context of endometriosis and dysmenorrhea may be overlooked or downplayed because pain associated with menstruation has been normalized. This normalization has led medical professionals, society at large, and even women themselves to view pelvic-related pain as an expected aspect of female reproductive anatomy (Markovic et al., 2008). The normalization of pelvic pain is often discussed in the studies as a gendered phenomenon (Wilson, 2021; Johansson, 1999). In conclusion, normalization of menstrual pain is one of the main factors contributing to the lack of recognition of certain types of pain, as well as the reasons behind possible under-diagnoses of menstrual-related conditions.

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endo teşhisi konunca yine doktorlara git, yine ağrılı geçiyor. yine evlenince geçer denmeler falan. Nüzhet

[238] From the patient perspective, one of the women participants from Whealan's research, who share experiences, is striking and a good representative of the general condition of delays: "The average delay in diagnosis for a woman my age (35) is nine years, that is how long it took for me to be diagnosed (W9)" (Whealan, 962).

The normalization of menstrual pain leads to under-diagnosis and insufficient treatment of conditions such as endometriosis and fibroids. Many women are taught to accept menstrual pain as a normal part of life, which delays diagnosis and treatment. Raising awareness and educating both healthcare providers and the public about the seriousness of menstrual pain is crucial for improving women's health outcomes.

5.2. Challenging Essentialism: A Radical Feminist Perspective on Menstrual-Related Conditions

This thesis challenges the essentialist medical perspective on women's reproductive health and menstrual-related conditions, which reduces them to medical disorders treatable with medication. Instead, it argues that these issues are complex and influenced by various factors, rejecting the idea that they can be reduced to solely medical or psychological problems. Taking a radical feminist approach, the study advocates for prioritizing women's wellness over the male-dominated biomedical model, promoting women's autonomy and agency in decisions regarding their reproductive health without falling into the trap of over-psychologizing the issue as "hysteria of women"[239]. Approaches to women's menstrual-related conditions can be divided into two main perspectives: the essentialist medical recognition of the issue and the psychological recognition. The essentialist medical perspective focuses on the biological aspects, while the psychological perspective addresses the mental and emotional dimensions. This thesis is an attempt to challenge the essentialist view that categorizes women's menstrual condition as a medical disorder curable by medication. The position defended here is that menstrual-related problems are complex issues, influenced by a range of factors, and should not be reduced to being solely a medical issue or dismissed as psychological 'hysteria'.

On the one hand, menstruation-related conditions of women such as menstrual pain, irregular menstrual pattern, menstrual cramps are regarded as medical disorders which can be cured once a drug/ painkiller/ anti-inflammatory is given. This

239 Some medical doctors think that these menstrual pain conditions are all in the head of women, which can perpetuate negative stereotypes about women.

essentialist view depends on the belief that the pain stems from a physiological reason (for example, some clinical findings that have identified a physiological reason for pain that is the production of uterine prostaglandins, see: Proctor and Farquhar, 2006, p.1134). Owing to the essentialist view, for treatment most of the research keeps the frame within simple analgesics and non-steroidal anti-inflammatories. In a similar vein, the second advice to cure menstrual pain is to use oral contraceptives if women also wish to avoid pregnancy (Proctor and Farquhar, 2006). Depending on the analgesics and contraceptives, this approach is insufficient to grasp the menstrual-related conditions. On the other side of the coin, menstruation-related conditions have been perceived as emotional or psychological problems. Some gynecological texts attribute the causes of dysmenorrhea to psychological problems such as anxiety, emotional instability, a flawed perspective on sexual health and menstruation (Proctor and Farquhar, 2006, p.1134). This approach regards menstrual related pain as a psychological issue. Moreover, it perpetuates negative stereotypes about women, portraying them as irrational, overly emotional, and hysterical based on their menstrual cycle (Olson et al., 2022, p.3).

In simpler terms, challenging the essentialist view, this thesis employs a radical feminist approach to the reproductive health of women and menstrual pain in the sense that I prioritize women's wellness over the male-dominated world; namely, patriarchal biomedical model which suppress women's reproductive body, and tries to fit women into a male-dominated system. Rather, this thesis argues that modern society should change to better suit women's needs in terms of their reproductive health.

This study takes a radical feminist perspective,[240] on the basis of its challenge to the medicalization of reproduction by questioning the power structures that dictate

240 Liberal feminism often celebrates the increase in opportunities for women as inherently positive. In contrast, radical feminism scrutinizes how these opportunities are framed within patriarchal systems. Radical feminists argue that opportunities which do not aim to challenge patriarchy may have adverse effects on women. For instance, they may criticize menstruation suppression pills, like Seasonale, as contrary to feminist values. Instead of suppressing menstruation, they advocate for restructuring workplaces to accommodate women's menstrual cycles. This perspective is detailed in Emily Martin's "The Woman in the Body" (1987), which discusses the demands placed on women in rigid work environments. Martin also cites the Beng women of Ivory Coast, who adapt their activities to align with women's cyclical changes, as a model of cultural recognition and support for women's natural rhythms (Aengst & Layne, 2014).

women's reproductive experiences and by advocating for women's autonomy, agency, and empowerment in making decisions about their bodies and reproductive health. Having a critical stance against the social structures that perpetuate gender inequality, this perspective emphasizes women's embodied experiences are vital. Within the context of the medicalization of reproductive health, radical feminists often critique how reproductive processes, including the menstrual cycle and related conditions addressed in this thesis, have been medicalized and controlled by institutional systems (Delaney et al., 1977; Martin 2003; Aengst & Layne, 2013).[241]

5.3. Critical Overview of the Overemphasis On the Hygiene Issue of Menstruation

> I was in middle 3. I think I'm 14 years old. Towards 15. Let's say 15. I guess my period started a little late compared to those around me. I was at school. I knew I was going to be. I had an intorduction and my aunt even gave me pads a few years ago. Saying that you never know when it will happen. He said that when it happens, you can use those pads. Therefore, I did not panic much when I got my period. I noticed.[242] Nüzhet
>
> I: How did you feel that day?
>
> So I was sad. So the thing came. Ugh, so now this happened to me. Feelings like I'm going to have to deal with this now. Other than that, I knew it was something biological. I accepted the incident. Only one thing, the hygiene part, scared me. Something will happen to your skirt. It created quite a phobia in me, whether it would fit up my skirt. And this actually has a lot of impact. In secondary school, to a private teaching institution in Izmir. Until that date, I was really uncomfortable with my period. It was a topic I tried to avoid. But there was a physics teacher. The man was a very conscious man. One day in class, he said something like this in class. Some of your girlfriends are going through such changes. There will be bleeding, it's normal. It will happen every month, normal. This is the statement he made in science class. This is a very normal process and you should be happy about it. This is something to be happy about and something to celebrate. If not, you should be worried.

241 Lesley Doyal is a British academic and author known for her work in social policy, gender studies, and public health. One of her notable books is "What Makes Women Sick? Gender and the Political Economy of Health" (1995).

242 Orta 3 teydim. 14 yaşında oluyorum sanırım. 15 e doğru. 15 diyelim. herhalde biraz geç başladı reglim etrafımdakilere göre. okuldaydım. olucağımdan haberim vardı. bana bir intorduction yapılmıştı hatta teyzem pedler falan vermişti bir kaç yıl öncesinden. ne zaman olacağı belli olmaz diyerek. olduğu zaman o pedeleri kullanırsın falan demişti. dolayısıyla regl olduğum zamanda çok panik olmadım. farkettim. Nüzhet

When something like this happens, it's a good thing, a healthy thing. It must be possible. Since I still remember that conversation, it changed my mind about it. Somehow, my father's reaction was compatible with this.[243] Nüzhet

I'm going to school again when I'm first colored[244]. At that time the pads were thick. Incels had not come out or they had just come out and were not available everywhere. They had precautions like huge thick cloth. Even if you use them, they are very uncomfortable. Well, of course, I had this discomfort about carrying it on me. Yes, is it clear? It was always said that it was such a colorful thing. You know, carrying it on me was causing trouble for me. Ah, yes, now that I remember, I thought of that. I mean, I don't know how it looks from the outside, I don't know what I was going through.[245] Jale

I mean, I remember being extremely shy and ashamed at that time. In those days, grocery stores used to wrap things in newspaper. He wrapped it in newspaper and I couldn't do anything. I wasn't just going to the market and buying orchids, for example. I had another need... I had my period, I had to go and get it. But I was always doing something. I was definitely buying something else. It was always yoghurt for me. You know, it is like it is for somebody.[246] Afet

When we started to go to university, and with the effect of studying health (nurse), of course, I realized that I did not know anything in the field of reproductive health until that age, and the issue of menstruation was never discussed.[247] Nermin

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[243] Ben: sen nasıl hissetmiştin o gün ? - Nüzhet: yani üzüldüm. yani şey geldi. üfff yani şimdi bu çıktı başıma. şimdi bunla uğraşmam gerekecek gibi hisler. Onun dışında biyolojik bir şey oldugunu biliyordum. kabullenmiştim olayı. bir tek şey, hijyen kısmı korkuttu beni. eteğine şey olacak. eteğime geçer mi bende bayağı bir fobi yarattı bende. bir de asıl şunun çok etkisi var. orta 2'de izmir'de bir dersaneye. o tarihe kadar regl konusunda gerçeten rahatsızdım yani. kaçınmaya çalıştığım bir konuydu. fakat bir fizik öğretmeni vardı. adam çaok bilinçli bir adamdı. bir gün sınıfta, sınıfta şöyle birşey söyledi. bazı kız arkadaşlarınız böyle böyle değişimlerden geçiyorlar. kanama olucak, normal. her ay olacak, normal. fen dersinde bu yaptığı açıklama. bu çok normal bir süreç ve buna sevinmeniz gerek. bu sevinilecek bir şey kutlanacak bir şey. asıl olmazsa telaşlanmanız lazım. böyle bir şey olduğu zaman iyi bir şey, sasğlıklı birşey. olamsı gerekioyr. o konuşmayı hala hatırladığıma göre bu konudakli şeyimi değiştirdi. babamın tepkisi de bununla uyumluydu nasıl olduysa. Nüzhet

[244] She uses “colored” to refer having a menstruation, she is on her period.

[245] Çok yine o ilk ilk renkli olduğumda okula gidiyorum. O zaman peddler kalındı. inceler çıkmamıştı ya da yeni yeni çıkmıştı her yerde yoktu. kocaman kalın bez gibi tedbirleri vardı. Onlardan kullanırsın da çok rahatsız yani. e tabii onu üzerimde taşımakla ilgili böyle bir rahatsızlığım vardı. Evet anlaşılıyor mu? Sürekli böyle bir renkli falan denirdi. Hani onun üstünde taşımak bir sıkıntı yaratıyordu bende böyle. Ay, evet bak şimdi hatırlayınca onu düşündüm. Yani böyle bir anlaşılıyor mu, dışarıdan nasıl görünüyor bilmem ne gibi bir şey yaşıyordum. Jale

[246] Yani aşırı derecede çekindiğimi, utandığımı hatırlıyorum o zaman. O zamanlarda şey hani bakkalların böyle gazete kağıdına sarmaları vardı. Gazete kağıdına sardı ve hiç şey yapamıyordum. Markete gidip mesela sadece orkid aalmıyordum. Başka bir ihtiyacım varmış da… regl olmuşum, evde o vakit bitmiş, gidip alıp gelmem gerekiyor. ama hep şey yapıyordum. Mutlaka başka bir şey daha alıyordum. Yoğurttu benim hep. Hani o da başka birineymiş gibi. Afet

[247] Üniversiteye geldiğimiz zaman da bir tık daha böyle biraz sağlık (hemşirelik) okumamın etkisiyle tabii ki aslında üreme sağlığı alanında o yaşa kadar hiçbir şey bilmediğimi, adet meselesinin hiç konuşulmadığını gördüm. Nermin

…

> But I didn't know how I was getting my period; it wasn't talked about. There are so many generalizations about menstruation, it's hidden, or even if it wasn't in my house, I saw that there were so many sentences constructed around the area between the legs. But this is a sign of fertility, that area between the legs, women give birth from there, but actually, it's also a source of shame. And virginity is also attributed to that area. Because of all these, we said we needed to work on reproductive health. We started to operate under the assumption that the understanding of reproductive health or ignorance of it in Turkey forms the basis of violence against women. I still defend this. Because when we look at the policies of all countries in the world, especially population policies, everything already goes through women's reproductive health. That is the source. On one hand, women are sanctified through motherhood, while on the other hand, they are cursed through the area between their legs. This has become a system constructed by the patriarchy, capitalism, and religion all coming together, and we perpetuate it by internalizing it. Therefore, I said that within my knowledge and by increasing what I know, I will advocate as much as I can in this field.[248] Nermin

Nermin's narrative focuses on the issue that menstruation, being a taboo subject[249], is often not discussed and remains a hidden phenomenon. She and her colleagues initiated a program aimed at enhancing women's knowledge about their health. She emphasizes, "We started working on reproductive health and the assumption that the understanding of reproductive health or ignorance in Turkey forms the basis of violence against women." This statement is crucial, as it highlights her argument that the lack of knowledge about their own reproductive health is a fundamental cause of violence against women.

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[248] Ama ben nasıl âdet olduğumu bilmiyorum, adet konuşulmuyor. Adetle ilgili bir sürü genelleme var, adet saklanıyor ya da bizim evde olmasa da bir baktım ki işte bacak arası üzerinden kurulan o kadar cümle var ki. Ama bu ama doğurganlığın işareti o bacak arası oradan doğuruyor kadınlar ama aslında ayıpları var. ama aslında bekaret oraya yüklenmiş. Gibi gibi… bütün bunlar bizim o zaman üreme sağlığı çalışmamız gerek dedik. üreme sağlığı anlayışının Türkiye'de ya da bilgisizliğin, kadına yönelik şiddetin temelini oluşturduğu varsayımıyla hareket etmeye başladık. Hala onu savunuyorum. Çünkü dünyadaki bütün ülkelerin politikalarına baktığımız zaman özellikle nüfus politikalarına kadın üreme sağlığı üzerinden gidiyor zaten her şey. Yani kaynak orası. Bir taraftan kadını annelikle kutsallaştırır iken bir taraftan da kadının bacak arası üzerinden kadını lanetleştirmesi, bu toplumun ataerkil kapitalizmin, dinin hepsinin bir araya gelerek aslında kurguladığı bir sistem haline gelmiş ve bizler de bunu kanıksayıp sürdürüyoruz. O yüzden de dedim ki ben de kendi bilgim dahilinde kendi bildiğimi artırarak olabildiğince bu alanda savunuculuk yapacağım. Nermin

249 Second wave feminists were actively engaged in the effort to normalize and remove the stigma surrounding women's bodily functions. They emphasized that cultural pressures, social constructs, and neurochemical factors played a significant, if not greater, role in women's mental health compared to their reproductive status (Chrisler, 2004, p.1).

Another interlocutor's words:

> Frankly, I did not receive such information when I was a teenager. No one has ever come to me and said, "There will be a change in you, you will experience these." But I was hearing these things in passing from the older sisters. Actually, I had an older sister too, but she wasn't talked about much. But I was aware that adults talked about such things all the time. When I had my first period, that is, I felt a little surprised and scared.[250] Şükran

A similar account of Leyla:

> I mean, it's interesting, I don't remember that much, you know? So there it is. I remember sharing it with my friends. We were 4 very close girls like this, we shared things with each other, but at home it was really about that... My mother's warning was that there was no distance at work. I mean, I knew something like this was happening because I saw my mother. But you know, my mother never shared anything with me about this. We don't have anything like that. I remember sharing it with my friends and I remember feeling a little more like, well, I've become a young girl now too. The feeling of growing up there. I remember my father buying me a pet. At least it's a comfort. So, we had some level of comfort in this regard. You know, nothing was being shared, though. My father used to do things, I mean he would bring us and take us away, we were not afraid of my father.[251] Leyla

Şükran and Leyla indicate that they did not learn from from their mothers about menstruation process. No one has told them explicitly about what they may experience. For Nüzhet, it is a little different, since she has lost her mother at the age of 12, she did not know whether her mother would have talked with her. However, her aunt and a friend of her father have given some information about the use of pads.

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[250] ergenlikte öyle bir bilgi almadım açıkçası. karşıma birnin geçip de sende değişiklik olacak, "bunları yaşayacaksın" diyen olmamıştı. ama bunları laf arasında duyuyordum büyük ablalardan. aslında ablam da vardı ama pek konuşulmuyordu. ama büyüklerin sürekli böyle bir şey konuştuğunun farkındaydım. kendim olduğum zaman da yani biraz şaşırmış ve korkmuş hissediyordum. Şükran

[251] Yani çok enteresan onu o kadar hatırlamıyorum, biliyor musun? Yani arkadaşlarımla paylaştığımı hatırlıyorum. Böyle çok yakın 4 kızdık, birbirimizle paylaşıyorduk ama evde doğru dürüst bununla ilgili… bir işte annemin bir uyarısı mesafesi olmadığı. yani ben annemi gördüğüm için biliyordum böyle bir şey olduğunu. ama hani annem benimle hiçbir zaman bununla ilgili bir paylaşımda bulunmadı. böyle bir şey yok yani bizde. Arkadaşlarınla paylaştığımı hatırlıyorum ve böyle biraz daha o hani işte artık ben de hani genç kız oldum falan hissini hatırlıyorum. Orada büyüme hissini. işte babamın bana pet almasını falan hatırlıyorum. Böyle en azından bir rahatlık. Yani bizde bu konuda bir yerden bir rahatlık da vardı. Hani bir şey paylaşılmıyordu ama. Babam ama şey yapardı, yani getirirdi götürdü, babamdan çekinmezdik. Leyla

My aunt may have told me about it when I was 12 or 13 years old. It didn't happen before. When I was 9-10 years old, I still didn't know why some women couldn't swim in the sea. These topics were very shameful and should not be talked about. I don't want to say it's a shame, but it's hygiene. An approach like if you don't talk about going to the toilet, you don't talk about your period either. It's not a sin. It was a subject that should not be talked about, not in terms of religion but in terms of social etiquette. And because I lost my mother when I was 12 years old. My mother didn't explain it to me until I was 12... I think about it again. no. I did not receive an explanation from my mother. After my mother died when I was 12, my aunt gave me the pads with a very short explanation. After I got my period in the middle 3rd, my father avoided the subject after that first congratulations and got a friend involved. Sister Fulya talked to me. He explained the types of pads, there are long ones and short ones. My sources are aunts and acquaintances, except for the mother. middle school science teacher.[252] Nüzhet

By the way, if you think it's appropriate, I'd like to share something. Compared to my peers, I started my first period somewhat later, transitioning from middle school to high school. My daughter, on the other hand, began menstruating at the end of fifth grade, entering puberty earlier than I did. I clearly remember our elementary school teacher when we were in fifth grade. We were in İzmir, and she said, "Boys can go outside, but girls should stay in the classroom." She talked to us about menstruation, explaining that it was a natural and healthy process. She told us that if this happens while you're at school, make sure to let me or, if you're at home, inform your mother. She emphasized that it was important and that we should pay attention to certain things regarding our general care. I remember it vividly because our teacher's effort to inform us was very valuable. For example, my teacher provided me with this information before my mother did. My mother, on the other hand, tended to focus more on moral and prohibitive aspects, whereas the teacher presented it in a more natural and less frightening manner. This contrast provided a clearer and less daunting perspective on womanhood.[253] Nuran

[252] teyzem 12 -13 yaşımda falan anlatmış olabilir. öncesinde yoktu. 9-10 yaşında iken hala bazı kadınların neden denize giremediğini bilmiyordum. bu konular çok ayıp, konuşulmaycak konulardı. ayıp demeyeyim ama hijyen. nasıl ki tuvalate gittiğinden bahsetmiyorsan regl olduğundan da bahsetmezsin gibi bir yaklaşım. günah değil. din açısından değil ama toplumsal görgü kuralları açısından konuşulmaması gereken bir konuydu. 12 yaşında da annemi kaybettiğim için. annem bana açıklamamıştı 12 yaşıma kadar... düşünüyorum tekrar. yok. annemden almadım bir açıklama. 12 yaşımda annem öldükten sonra teyzem çok kısa bir açıklama ile pedleri verdi. orta 3 te regl olduktan sonra babam o ilk tebrikten sonra o konudan kaçıp bir arkadaşını devreye soktu. fulya abla benle konuşmuştu. ped çeşitlerini anlatmıştı, uzunu var, kısası var. benim kaynağım anne hariç teyze ve tanıdık. orta okuldaki fen hocası. Nüzhet

[253] yeri gelmişken uygun görürsen anlatayım ve ben yaşıtlarıma göre kendi doğduğum şeye de kuşakta biraz geç orta ikiden orta üçe geçerken ilk reglimi başladı. Kızımınki de beşinci sınıfı bitirdiği zaman yani kızım bana göre daha erken ergenliğe girdi. Hiç unutmuyorum ilkokul öğretmenimiz beşinci sınıftayken. Izmir'deydik. bugün dedi. Şey olsun, çocuklar erkekler çıkabilir. Kızlar sınıfta kalsınlar dedi ve bize regl kanımasından bahsetti ve bunu çok sağlıklı bir şey olduğundan anlattı ve böyle bir kanama olması halinde okuldaysanız bana evdeyseniz annenizle mutlaka haber verin. Böyle bir şey yaşadığınızı ve. Genel bakımınızla ilgili dikkat etmeniz gereken şeyler olacak diye. çok kıymetlidir ve bunu hiç unutmam ben yani. Hani o öğretmenimizin bizi bilgilendirmesi. Mesela annemden önce

During the interviews, it was consistently mentioned by interlocutors that mothers in previous generations did not provide guidance on topics related to menstruation or menstrual conditions.

As a rare case, one of the respondents indicate that she received a congurajutation from her father:

> I went to my father and told him. You can write this too. It was one of the most positive reactions my father had ever given. I just said it to let you know. Just like that, I got my period in the evening. He returned very cheerful. He said "oh, congratulations" and hugged me. He reacted out of my normal father's character. Even I was surprised by this reaction. For example, when I wanted to wax, all hell broke loose. his support is not for femininity. I guess someone told him that if your daughter tells you she's on her period, do it this way. I don't know whether he felt like it or not, but he reacted very positively and hugged me. He congratulated. (He lost his mother when he was 12 and lived with his father).[254] Nüzhet

Nüzhet's experience of receiving a congratulatory reaction from her father upon getting her first period is notably unique and stands out among other interlocutors. It is rare to hear of fathers responding with such positive reinforcement and support regarding their daughters' menstruation (for this generation). Typically, discussions around menstruation is covered in discomfort or even embarrassment, particularly between fathers and daughters. Nüzhet's father responded with unexpected encouragement, congratulating and hugging her. This reaction not only provided Nüzhet with a positive and supportive memory but also reflects an impactful approach to acknowledging a significant milestone in a young woman's life, menarsh.[255]

öğretmenim bana bu bilgiyi vermişti. Annemle mesela bu tür şeyleri… annem daha günahlar ve yasaklar şeylerini, bu tür alt bilgileri verip. Bir yandan da esasında şeyden de yani hani işte o kadının doğallığından da bir böyle korkutucu. Daha kasvetli diyeyim. Açıkçası bir tablo açık, yani kadınlıkla alakalı. Nuran

254 babama gidip söyledim. bunu da yazabilirsin. babamın hayatında verdiği en olumlu tepkilerden biri idi. sadece haber vermek için söyledim. böyle böyle regl oldum diye akşam. o da çok neşeli bir şekilde döndü. aaa tebrik ederim deyip sarıldı falan. normal babamın karakterinin dışında bir tepki vermişti. hatta ben de şaşırmıştım bu tepkisine. örneğin ağda yapmak istediğim zaman kıyameti kopaemıştı. desteği kadınlık için değil de. herhalde birisi ona söylemiş, kızın sana regl oldum derse böyle böyle yap diye. içinden gelerek mi değil mi bilmiyorum ama çok olumlu tepki vererek sarılmıştı. tebrik etmişti. (annesini 12 yaşında kaybetmişti babası ile yaşıyordu). Nüzhet

255 In Chapter One, I discussed the early feminist studies about menarch and menstruation.

> Me: Have you been able to connect this shame and ignorance you mentioned to any specific reasons for why it developed? It seems like you've established some relationship with it. You talked about its root causes—how did you address them?
>
> D: By seeing it for what it is. I couldn't ignore it any longer. The source of this shame comes from the family and society... We never talked about it. I didn't know what menstruation was. No one explained it to me. In society, menstruation is considered something shameful or dirty. You're told not to touch anything or do anything while on your period. There's been this perception that it's something dirty. But in reality, we're talking about something that is a fundamental part of being a woman, something that makes you who you are. It's a shedding of the uterine lining because there's no fertilization by sperm. In fact, it's something incredibly valuable and rich in nutrients. I've been carrying something that signifies a creation process, and I hadn't been aware of it until now. Why?[256]

Şükran shared an example involving her niece, the daughter of her sister. When her niece had her first period, Sema wanted to celebrate this milestone and involve family members to boost her niece's self-esteem. She reflected on her own past experiences with menstruation, which had been filled with shame and fear. After coming to terms with her own perceptions and embracing the beauty of her menstrual cycle in a more positive and creative light, Sema wanted to pass on this positive perspective to the next generation. Thus, she organized a small celebration for her niece to mark this important event in a supportive and affirming way.

> Menstruation was always accompanied by embarrassment for me. I remember being told, "Are you on your period? Be careful not to touch anything" or "Make sure it doesn't show." Whenever there was bleeding, we would constantly check to see if it was visible or if the pad was showing. There was always a sense of shame and fear—wondering if anyone saw. I confronted these feelings, and it was very liberating for me. When my niece got her first period, I decided to celebrate it with a party. I made a promise to myself that I would do something special. I remember clearly that I baked a

[256] Ben: bu utanç dediğin, bilmeme dedeğin şeyleri bir yere bağlayabildin mi neden böyle olduguna dair. onunla ilgili bir ilişki kurmuşsun gibi geldi. o kök nedneler den bahsettin. onları nasıl çözdün?
D: işte görerek yani. daha fazla görmemezlikten gelemedim. bu utancın sebebi aileden, toplumdan... hiç konuşmamaşız. reglinin ne olduğunu bilmiyorum. bana kimse anlatmamış. toplumda zaten regl oldun mu ayıp günah gibi pis gibi birşeymiş gibi. ama elin, birşeye sürmemlisin , bir şey yapılmaz adetliyken sanki. hep pis birşeyin içindeymışiz gibi ibr algı oluşmuş. halbuki aslında kadının en yan, b,r canlısın özünü oluşturan birşeyden bahsediyoruz. spermle birleşse bir canlı olucak. spermle birleşmediği için rahim duvarından aatılan bir kanamdan bahsediyoruz. aslında o kadar değerli ve besin değeri yüksek bir şey taşıyorum içimde. yani bir yaratımın gerçekleştiği bir yer var ve onun farkında bu zamana kadar varamamışım. neden?

> cake at home. My parents, my sister, and everyone were there. I said, "Today, my niece got her first period." Just like how boys have circumcision celebrations, I organized a small party for her. I even had her blow out candles and told her, "Congratulations, you've become a young woman." It was a sweet and celebratory moment. My father and uncle were a bit surprised, but no one made it awkward. My niece was also a bit surprised but seemed to appreciate it. Although she felt a bit embarrassed, I wanted to normalize the situation. It was a transitional moment—now you are a young woman, and we all know this. It's not a secret or something to be ashamed of. We can celebrate it with a cake. It was something I really wanted to do, and we did it.[257] Şükran

These excerpts from women interviewed in my fieldwork highlight several common themes related to menstruation. First of all, taboo and silence surrounding menstruation among. Across the narratives, women express that the topic was either not discussed at all or only in hushed tones among siblings, female relatives or friends. This lack of open discussion contributes to feelings of confusion, shame, and even fear when experiencing menstruation for the first time. As a second emerging topic is the lack of formal education on reproductive health. There is a notable absence of guidance from mothers or elder women about menstruation. Instead, informal sources such as friends, older sisters, or in rare cases, teachers, provided limited information. This gap in formal education contributes to misinformation and discomfort among young girls in their menarsh. As a third emerging theme is the cultural and social stigma[258] surrounding the menstruation. Menstruation is often viewed as a shameful or inappropriate topic for public discussion. Gender dynamics also play a significant role, as fathers and male figures are generally excluded from conversations about menstruation, reinforcing societal norms that associate menstruation with secrecy and discomfort. However, Nüzhet's experience with her

[257] hep böyle utanılmış. adet misin? aman sen elini birşeye sürme. ya da gözükmesin. ah işte kanama olduğunda hep böyle arkaya bakardık. çıktı mı? gözüküyor mu, bez mi gözüküyor mu? işte, acaba yayıldı mı? hep bir utanç. bir korkaklık var. birisi gördü mü? onlarla yüzleştim. ve bu beni çok rahatlattı. ve şunu yaptım. yeğenim adet olduğunda ona bir parti yaptık. ilk adet olduğunda dedim ki benim ahdım vardı. hiç unutmuyorum. evde bir pasta yaptım. annem, babam, ablam, herkes yani. bugün yeğenim ilk adetini oldu. hani erkeklerde nasıl sünnet olunur ve böyle kutlanır. biz de hiç unutmuyorum. mum üfletmiştim. "tebrik ederim , bir genç kız oldun" .güzel tatlı bir şe bu. kutlanası bir şey. babam ve eniştem biraz şaşkınlık içindeydi ama kimse de bozmadı.Yiğenim de şaşkındı ama biraz hoşuna gitti. utandı gibi .ama durumu normalize etmek istedim. bir geçiş süreci var. artık sen bir genç kadınsın. biz hepimiz biliyoruz bunu. gizli saklı değil. ayıplanacak bir şey değil. utanılacak bir şey değil. bak, pastayla bunu kutlayabiliriz. güzel bir şey yani.bu çok istediğim birşeydi. yaptık.

[258] Early sociological studies by Roth, Goffman, and Davis marked the emergence of this concept see Chapter Two. For details about "menstrual stigma" see the footnote 151.

father's positive response highlights a rare instance of supportive engagement, contrasting with the prevailing silence. Taboo and silence, lack of formal education about menstruation, and menstrual stigma are not new topics; in fact, these have long been covered in studies on menstruation. In this thesis fieldwork, I also see these themes emerging. However, I want to take a step further and analyze the emphasis on hygiene in relation to menstruation. In the course of this doctoral research, I have observed the emergence of certain thematic elements. Nevertheless, I aim to delve deeper by conducting an analysis of the overemphasis placed on hygiene in the context of menstruation. In the following section I will delve into this analysis with relation to epistemic injustice.

5.3.1. Reassessing the Focus on Menstrual Hygiene

This section critically examines the predominant focus on menstrual hygiene, reassessing its benefits and drawbacks, and argues for a more holistic approach to understanding and addressing menstrual health. The WHO has a statement on menstrual health and rights.[259] On 22 June 2022, at the 50th session of the *Human Rights Council Panel* discussion, there were statements concerning menstrual hygiene management, human rights, and gender equality:

> WHO calls for three actions. Firstly, to recognize and frame menstruation as a health issue, not a hygiene issue – a health issue with physical, psychological, and social dimensions, and one that needs to be addressed in the perspective of a life course – from before menarche to after menopause. Secondly, to recognize that menstrual health means that women and girls and other people who menstruate, have access to information and education about it; to the menstrual products they need; water, sanitation, and disposal facilities; to competent and emphatic care when needed; to live, study and work in an environment in which menstruation is seen as positive and healthy not something to be ashamed of; and to fully participate in work and social activities. Thirdly, to ensure that these activities are included in the relevant sectoral work plans and budgets, and their performance is measured.

WHO advocates for three crucial actions. Among them, the remarkable one for this thesis framework is the recognition and reframing of menstruation as a health

259 For the statement see: World Health Organization. (2022, June 22). WHO Statement on Menstrual Health and rights. World Health Organization. https://www.who.int/news/item/22-06-2022-who-statement-on-menstrual-health-and-rights

concern, as opposed to a mere hygiene issue. This statement is a vital call to action; however, it is also an indicator that menstruation had been taken into consideration by WHO action programs as a hygiene issue previously. Especially in terms of their approach to women in third world countries, menstruation had been recognized as a hygiene issue. WHO emphasizes the importance of access to clean and safe menstrual hygiene facilities, as well as sustainable menstrual hygiene products, to ensure the health and well-being of females who menstruate (Clark & As Sy, 2020). They advocate for policies and programs that address menstrual hygiene management as part of broader efforts to promote sexual and reproductive health and gender equality. Similarly, The WB also considers sanitation and hygiene when it comes to menstrual health. "Access to affordable and sustainable menstrual hygiene products (e.g. menstrual cloths, reusable pads, disposable pads, menstrual cups and tampons) is key to improving menstrual health and hygiene" (The World Bank Group, 2021). WB's argument is that menstrual products should be introduced with educational materials. They offer an approach, which combines "education with infrastructure, products, and efforts to tackle the societal taboos and stigma surrounding the issue" to achieve good menstrual health hygiene (The WB Group, 2021). In parallel with this perspective, Menstrual Hygiene Day (MH Day)[260] was initiated by the German non-profit organization *Network for Water, Sanitation and Hygiene* WASH United[261] in 2013. MH Day is also recognized in Turkey and in 2023 one of the initiatives aimed at promoting menstrual health and hygiene includes the efforts of the United Nations Population Fund (UNFPA). UNFPA provided education for women who menstruate, ensuring access to safe sanitation facilities, particularly in displacement camps, and distributing 'dignity kits'[262] that contain items such as sanitary women pads, soap, personal hygiene supplies, and underwear.

260 Menstrual Hygiene Day (MH Day) is a worldwide initiative that aims to raise awareness about the importance of menstrual health and hygiene (MHH). It brings together non-profits, government agencies, individuals, the private sector, and the media to promote good menstrual health practices. For details see: https://menstrualhygieneday.org/about/about-mhday/

261 WASH United is the initiator and international secretariat and global coordinator of MH Day. They are working with more than 1,000 partner organizations such as UNICEF, UNFPA, the WB, WaterAid, GIZ and hundreds of local organizations. Most of their local partners are based in Sub-Saharan Africa and South Asia. The main point is to provide access and affordability to the menstrual products.

262 For the details for UNFPA Basic Dignity Kit see: https://www.unfpa.org/resources/unfpa-basic-dignity-kit, and UNFPA's webpage: https://turkiye.unfpa.org/en/menstrual-hygiene-day-2023

In all these global initiatives, the main concern is to solve the limited access to hygienic menstrual products. UNFPA provide education for raising awareness in menstrual health; by which they refer to the taboos or riddled myths about menstruation, and to the exclusion of women from daily activities because of menstrual stigma[263], shame, or discrimination (Menstrual health 2024). Moreover, according to their report, *Menstrual Hygiene Management among Refugee Women and Girls in Türkiye,* some nations have tackled the issue of *period poverty*, which refers to the challenge of accessing menstrual products due to financial constraints (2022). Therefore, the main objective of UNFPA and the other above-mentioned international organizations is to provide access to menstrual products rather than providing menstrual health awareness or health.[264]

At this point, I would like to provide a brief assessment on the WHO's statement[265] regarding menstrual health and rights.

> WHO calls for three actions. Firstly, to recognize and frame menstruation as a health issue, not a hygiene issue – a health issue with physical, psychological, and social dimensions, and one that needs to be addressed in the perspective of a life course … Secondly, to recognize that menstrual health means that women and girls … *have access to information and education about it; to the menstrual products they need; water, sanitation, and disposal facilities* [emphasis added]; to competent and empathic care when needed; to live,

263 Menstrual stigma encompasses the prejudicial attitudes directed towards menstruation and those who undergo this natural biological process. It manifests as the portrayal of the menstruating body as aberrant and unappealing. This negative perception often leads to social ostracization, psychological distress, and discriminatory practices against individuals who menstruate. Such stigma may arise from cultural taboos, religious beliefs, and historical norms surrounding menstruation. Its persistence underscores broader issues of gender inequality and the marginalization of bodily experiences in societal discourse (Johnston-Robledo & Chrisler, 2011).

264 Below are some examples of humanitarian aid facilities conducted in Turkey that you may find useful to review:
Menstrual hygiene management among refugee women and girls in Türkiye research report. UNFPA Türkiye. (2022, December 5). https://turkiye.unfpa.org/en/menstrual-hygiene-management-research-report
Türkiye: UNFPA - Menstrual Hygiene Management among refugee women and girls in Türkiye - September 2022 [En/TR] - Türkiye. Relief Web. (2022, November 23). https://reliefweb.int/report/turkiye/turkiye-unfpa-menstrual-hygiene-management-among-refugee-women-and-girls-turkiye-september-2022-entr
https://turkiye.unfpa.org/en/menstrual-hygiene-management-research-report-short-video

265 World Health Organization. (2022, June 22). Who statement on Menstrual Health and rights. World Health Organization. https://www.who.int/news/item/22-06-2022-who-statement-on-menstrual-health-and-rights

> study and work in an environment in which menstruation is seen as positive and healthy not something to be ashamed of; and *to fully participate in work and social activities* [emphasis added]. Thirdly, to ensure that these activities are included in the relevant sectoral work plans and budgets, and their performance is measured (2022).

Access to comprehensive and relevant information regarding menstruation is crucial for women's health and well-being. Nevertheless, it is essential to consider who determines the information that is made available to girls and women. From a critical discourse analysis point of view, in the WHO's statement, it is a very critical point that the emphasis is on the products women may need as sanitation and disposal facilities. I would like to ask the question: is this the information that is relevant to addressing women's menstrual health concerns? It is important to evaluate whether the information being provided by WHO meets the actual needs of women in terms of their menstrual health. For instance, is there any information provided about lunar cycles which is directly related with menstrual health that women may need?

What kind of information are we trying to provide to women? These questions can be answered with relation to the discussions around the dominance in knowledge production and thus account for the persistence of "epistemic injustice". *Epistemic injustice* refers to situations where the systems and structures that produce knowledge lead to various forms of marginalization. Drawing on the research conducted by Fricker (2007) and Tuana (2019), Hutton and Cappellini (2022) posits, "Epistemic injustice occurs when dominant structures in knowledge production result in; exclusion and silencing, invisibility, inaudibility and having one's contributions distorted, misheard and/or having diminished status in communicative practices" (p. 156). Epistemic injustice can enclose exclusion, where certain perspectives are actively kept out of discussions or decision-making processes. In a similar way, silencing occurs when people are prevented from expressing their viewpoints, often through social pressures or power dynamics. Invisibility refers to being ignored, often due to biases or prejudices that prioritize certain types of knowledge or experiences over others. Inaudibility is specifically related to not being heard, even when one does have the opportunity to speak (see, for example, Koch, 2021; Soares, 2023).

Additionally, epistemic injustice can involve having people's contributions distorted or misrepresented. This can happen when dominant narratives or perspectives overshadow or misinterpret alternative viewpoints, leading to a lack of recognition or validation for those contributions. Overall, epistemic injustice highlights the systemic biases and inequalities that can arise in knowledge production and dissemination, ultimately impacting who gets to participate in shaping our collective understanding of the world and whose knowledge is valued and recognized.[266]

In WHO'S statement above, there is a notable focus on addressing feelings of shame in discussions about menstruation. Additionally, there is an emphasis on enabling women to fully engage in professional and social activities during their menstrual cycles. It is important to critically examine why participation in these activities is seen as a priority for women during menstruation, and whether there may be other needs that are not being adequately addressed in existing information and resources.

More to elaborate on the critical evaluation of WHO's approach to women's health, I provide the following quotation from the website of the WHO, the statement about "Women's Health" under the "Health Topics" heading:

> Being a man or a woman has a significant impact on health, as a result of both biological and gender-related differences. The health of women and girls is of particular concern because, in many societies, they are disadvantaged by discrimination rooted in sociocultural factors. For example, women and girls face increased vulnerability to HIV/AIDS.
>
> Some of the sociocultural factors that prevent women and girls to benefit from quality health services and attaining the best possible level of health include:
>
> - unequal power relationships between men and women;
> - social norms that decrease education and paid employment opportunities;
> - an exclusive focus on women's reproductive roles; and
> - potential or actual experience of physical, sexual and emotional violence.

266 For a detailed discussion about the WHO's Self-Image of an epistemic authority, see:
Gruszczynski, L., & Melillo, M. (2022). The Uneasy Coexistence of Expertise and Politics in the World Health Organization: Learning from the Experience of the Early Response to the covid-19 Pandemic. International Organizations Law Review, 19(2), 301-331. https://doi.org/10.1163/15723747-20220001

The first notable aspect in this quote is how it addresses women's health as a particular concern due to discrimination rooted in sociocultural factors. According to this text, women's health is approached as a cultural-specific issue with the emphasis on *many societies*. It implies that *(some)* women are disadvantaged and face discrimination in *some societies.* However, is this really the main point that makes women's health important? By mentioning many societies and cultures and pointing out that women face discrimination due to cultural and social reasons, it shifts the focus of the topic. I contend that when we frame the issue in terms of socio-cultural disparities and unequal access to healthcare, it shifts and dilutes the primary focus of the discussion, which is women's health.

In a similar way, the second point in the statement follows with the increased vulnerability of women due to HIV/AIDS. In this statement, the barrier to accessing quality healthcare services is attributed to sociocultural factors and disparities in power dynamics between individuals based on gender. This viewpoint fails to scrutinize the quality of health care offered to women, focusing solely on the barriers to accessing the service. However, health service accessibility is not the primary concern of the statement. While both statements are true and important issues, they are not necessarily the first two sentences of a statement trying to explain why women's health is important. Within this context, I would like to take attention to two primary concerns that necessitate a critical examination in approaching women's health and more specifically menstruation. In the forthcoming section, I will address two critiques: the first regarding the evaluation of global initiatives' facilities on women's issues from a post-development feminist perspective, and the second critiquing the predominant approach to menstruation issues through the lens of hygiene, as criticized by radical feminists.

5.3.2. Critical Evaluation of Global Initiatives' Development Approach

> Orchidists (orkidçiler)[267] would come to schools and provide menstrual pads, etc. I was in high school then. When the orchidists come, come on guys, we'll tell the girls something. So this is the attitude. I was upset about this and I

[267] The term "orkidçiler" refers to individuals or groups involved in providing educational sessions or materials related to reproductive health, including menstrual pads, to schools.

> said, "Why don't we get sexual education?" That's when I said this in the 90's. 91-92- 90. In those years, and while the boys at school were chanting "Long live Nermin" in class, the girlfriends said: "Don't be ridiculous, you are embarrassing us.[268] Nermin

Firstly, from a feminist post-development approach,[269] The discourse of the international organizations can be criticized in terms of the certain representation of the disadvantaged women. The discussion surrounding the advancement of marginalized women in under-developed and developing countries within the context of development efforts has faced criticism from feminist post-development scholars (For example: Chandra Mohanty, 1984; Moghadam, 2003; Narayan & Harding, 2000; Kabeer, 2015). This feminist approach challenges the mainstream development arguments by highlighting their gendered biases, unequal power dynamics, and the marginalization of women's voices and experiences within development initiatives (Saunders, 2002). A recent study of Alhelou et al. (2022), examining global initiatives' policies through the lens of human rights, involves conducting a comprehensive examination of policy documents, supplemented by in-depth interviews with a range of stakeholders including government officials, civil society representatives, academics, United Nations (UN) personnel, and other subject matter experts focused on menstrual policy. Their analysis shows "how policies centered girls but ignored menstrual needs across the life-course. They also ignored the needs of menstruators facing marginalization due to compounded stigma, unequal power relationships, and structural inequalities" (p.15). Instrumentalization of women in such narratives is underlined and shows how the concept of "girling" and "girl-powering" of development" is perpetuated (p.16). "Portraying girls' empowerment as a lever for socioeconomic development can overshadow the goal of empowering girls in the first place and may overemphasize material menstrual needs" (Alhelou et al., 2022, p. 16).

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[268] *Okullara orkidçiler gelirdi, adetle ilgili ped temin ederlerdi falan filan. lisedeydim ben o zaman. Orkidçiler gelince, haydi erkekler dışarı, biz kızlara bişey anlatıcaz. tavır bu yani. ben buna bozulmuştum ve üstüne dedim ki, "ya biz neden cinsel eğitim almıyoruz" demiştim. işte 90 yılında bunu söylediğimde. 91-92- 90. O yıllarda ve okuldaki erkek öğrenciler sınıfta "Nermin çok yaşa" diye şakşak yaparken, kız arkadaşlar şey yapmışlardı: "Saçmalama bizi utandırıyorsun". Nermin*

269 The feminist post-development approach is a theoretical framework which mainly critiques traditional development framework from a feminist perspective (Saunders, 2002). This approach seeks to deconstruct the patriarchal structures inherent in development discourse and practice.

Instrumentalization of women in development narrative can be traced in other UN funded projects. With a similar point of view, in a thesis study critiquing the Reproductive Health Program[270] in Turkey from a post-development feminist perspective, Özden argues that,

> This attempt is influenced by a determination for engendering women's empowerment by granting them reproductive knowledge and choice. However, these terms of "risk", "pathology" and "healthiness" are already loaded with ideologies pertaining to the bio-politics of women's bodies, patriarchy and global regimes of development. The medicalized conceptualization of women's reproduction as defined in terms of "risk" legitimizes the subjection of women's bodies to the male oriented medical profession. It persuades women to conceive their reproduction and their bodies as sites of risk, which engenders a loss of autonomy. (2010, p.135)

While in this study, the focus was on the medicalized conceptualization of women's reproduction as defined in terms of "risk"; I argue that viewing menstruation as a 'risk' issue has similar consequences resulting in a diminishing of independence of women. In both cases, the same logic functions as the legitimization of the subjection of women's bodies to the male oriented medical profession.

5.3.2.1. Influence of Global Programs on Menstrual Health Policy

In terms of menstrual hygiene and the approach of the global organizations and NGOs' action programs for the disadvantaged women, Bobel's analysis gives us a comprehensive insight. Bobel's book, *The Managed Body Developing Girls and Menstrual Health in the Global South,* examines "Menstrual Hygiene Management" (MHM) as a social movement aimed at supporting menstruating girls in regions of the Global South. Upon initial inspection, the title of the book gives us insight about the connection between the "development discourse" that has been criticized by feminist scholars and the aim of 'developing' girls' menstrual habits as a management issue. With Bobel's sentences (2020, p.35):

270 The implementation of the European Union funded Reproductive Health Program in Turkey is analyzed in the sociology thesis study. Özden posits that, "Reproductive Health Program that depends on a framework that aims to empower the poor women to prevent reproductive health risk situations and enlarge their reproductive choices, without reflecting on or critiquing the role of the general political structures and the processes which were caused by the economic globalization and neoliberal policies" (2010, p.2).

> The title Developing Girls and Menstrual Health in the Global South embraces the dual meanings of development. Development refers to the global development industry, that is, the complex relations of funders, organizations, and their publics that endeavor to improve the quality of life for the people in low- and middle-income countries The word also refers to the social and biological changes facing girls as they transition from girl to woman. As girls develop, so do their countries, but both exist in precarious states. What will it take for them to both realize their potentials? Per the logics of MHM and the Girl Effect, the key to unlocking the potential of girls and their countries is a menstrual product. The developing, or pubertal, girl in the context of development is a rich resource, to herself and to her community, but not until her menstrual body is tamed. Bloodless and respectable. Dignified. Freedom, through this lens, ironically depends on containment.

Bobel presents a nuanced critique of the complex discourse of MHM, highlighting its connections with the Water, Sanitation, and Hygiene (WASH) development sector. She reveals how MHM constructs its discourse and addresses the menstruation issue for its strategic agenda. She argues that MHM organizations often rely on insufficient evidence and sensationalized portrayals to depict a so-called "hygienic crisis". Through their promotion of the hygienist discourse, their intervention can gain legitimacy, that she argues MHM becomes a neocolonial project (p.59). Moreover, she contends that the predominant focus on action plans that are centered around specific products such as distribution of disposable sanitary pads[271] to girls fails to challenge the social construction of menstruation in terms of signifying the female body as unclean and in need of concealment during her period.

Although MHM initiatives claim to protect the 'dignity'[272] of girls, Bobel argues that they mainly promote technological solutions that reinforce consumerism, thus perpetuating rather than challenging the stigma surrounding menstruation. Focus on product-based solutions fails to challenge social constructs around menstruation. The equation of product-use with freedom has parallels with liberal feminist ideals.

271 About a critical evaluation of the history of disposable sanitary pads and the sanitization of the human body in the twentieth century, see Tarzibachi, E. (2022). Advertising "Feminine Protectors:" From Hygiene to Women's Liberation. In: Menstrual Bodies and Gender. Palgrave Macmillan, Singapore.

272 Discourse of dignity is used in UNFPA's menstrual hygiene management facilities as they distribute 'dignity kits' (sanitary pads etc.) to girls and women in refugee camps.

Liberal feminist approaches to Women in Development (WID) have been criticized in terms of several key points. First, the focus on logistical solutions such as providing access to education and economic opportunities for women, just like providing sanitary products[273] for menstrual hygiene, overlook deeper structural issues. Second, liberal feminist approaches may overlook 'intractable impediments' to women's development, such as entrenched patriarchal norms and systemic inequalities. These issues are often deeply rooted in social, cultural, and economic structures and cannot be addressed solely through logistical solutions. Third, liberal feminist approaches to WID often fail to challenge the dominance and influence of Western agendas. This can perpetuate a power imbalance in development discourse and overlook the diverse experiences and needs of women in different contexts. Lastly, despite their efforts, liberal feminist ideals may not provide effective tools to dismantle patriarchal gender ideologies. These ideologies perpetuate gender inequality and discrimination against women; so, addressing them requires more than just providing material resources (Marchand & Parpart, 2003). Overall, this critique suggests that while liberal feminist approaches to WID have made important contributions, they may need to broaden their focus and address deeper structural and ideological barriers to women's issues.

In a comparable fashion, Chorev's book "The WHO between North and South" (2012), focuses on the WHO and its role in shaping global health policies, particularly in relation to the North-South divide. Chorev examines how the WHO navigates the complex dynamics between wealthy, industrialized nations (the North) and less developed and the so-called developing countries (the South), and how this influences its approach to global health and development. In the book, the main argument is that the WHO's activities and priorities are influenced by the power

[273] The marketing practices of the menstrual product industry has been criticized. Historically, companies have portrayed disposable pads and tampons as necessary for protecting women from their supposedly weak bodies during menstruation. This portrayal reinforces outdated and patriarchal ideas about women's bodies and menstruation (Tarzibachi; 2022). In a more contemporary context, industry have rebranded themselves as selling "Feminine Care" or "femcare" products. These items are often prominently displayed in the "feminine protection" aisle of pharmacies and supermarkets. In essence, this highlights the irony of how the industry perpetuates notions of female vulnerability and inferiority through their marketing, while simultaneously positioning themselves as providers of care and protection for women. For a detailed discussion see:
Tarzibachi, E. (2022). Advertising "Feminine Protectors:" From Hygiene to Women's Liberation. In: Menstrual Bodies and Gender. Palgrave Macmillan, Singapore

dynamics between these regions, as well as by broader political and economic forces.[274] The analysis sheds light on how the WHO operates within the context of global governance and development, and how it seeks to balance competing interests and priorities while striving to improve health outcomes worldwide. Therefore, in a general term, the impact array of these bureaucracies are wide spanning issues from public health to nuclear proliferation and women's rights. Consequently, it is argued that international bureaucracies emerge not merely as purposive actors but also as strategic ones, navigating power dynamics and interests within the global arena (Chorev, 2012).

5.3.3. Challenging the Hygiene Discourse: Towards Comprehensive Menstrual Health

Secondly, one of the primary concerns is that the research on menstruation is often limited to menstrual hygiene (Winkler et al., 2023).

Recognized by the WHO as a health and human rights issue, menstruation is a key indicator of women's health. Menstrual health is an integral component to achieving many of the Sustainable Development Goals. However, research on menstruation is often limited to menstrual hygiene and does not comprehensively address it from a life course and justice perspective. Due to resource constraints, researchers often lack financial support to expand their research beyond menstrual hygiene and are unable to utilize it to advance evidence-informed policy and programs for menstrual health" (Winkler et al., 2023). The overwhelming emphasis on menstrual hygiene often presents researchers with hurdles to extend their studies beyond hygiene issues.

In a similar vein, the over emphasis on the hygiene aspect is criticized from a human rights perspective. According to Zivi (2020) and Winkler (2021), the global discourse on hygiene issues pertaining to human rights and human dignity has been

[274] Moreover, theoretical frameworks such as constructivism and principal-agent theory, as outlined by Chorev, offer valuable perspectives on the functioning of international organizations, emphasizing their multifaceted dynamics beyond state-centric bargaining. She explores how the organization's decisions are often shaped by the interests and agendas of its member states, which can sometimes lead to tensions and conflicts over health policy (2012).

manipulated within menstrual advocacy efforts. Their analysis argues that these advocacy efforts aimed at promoting narrow views of menstrual requirements. This suggests that while discussions around human rights and dignity are invoked by the policies, they are often used superficially or insincerely within the context of menstrual advocacy to serve specific agendas or limited understandings of menstrual needs. In essence, the broader principles of human rights and dignity are co-opted to advance agendas that may not fully address the multifaceted needs of menstruating women. Winkler calls this as "tokenism" and "reductionism"; while Zivi calls this "hiding in public". Therefore, the concepts of human rights and human dignity are instrumentalized and tokenized in the efforts of global menstrual policies as in the case that "dignity" is used to refer to menstrual management and cleanliness of girls (Bobel, 2019). This approach reduces the dignity to management of menstruation, maintaining privacy, and ensuring cleanliness (Bobel, 2019). Nevertheless, despite this manipulation of discourse, it remains crucial to recognize and address the broader issues surrounding menstrual health and hygiene, ensuring that advocacy efforts truly serve the diverse and complex needs of menstruating individuals. Alhelou et al. (2022) underlines, within the human rights framework, emphasis is placed on agency, autonomy, and substantive equality, highlighting the importance of empowering individuals to make informed choices about their bodies and health without discrimination or stigma.[275]

Olson et al. (2022) conducted an analysis on the effectiveness of policies concerning menstrual health and hygiene in addressing and combating menstrual stigma. "Policies raised awareness of menstruation, often with great noise, but they simultaneously called for hiding and concealing any actual, visible signs of menstruation and its embodied messiness. Educational initiatives mostly promoted bodily management and control, rather than agency and autonomy" (Olson et al., 2022). In the context of menstruation health, over-emphasis on the "hygiene" hinders the importance of menstrual related health conditions of women (Olson et al., 2022).

275 "However, human rights are understood as a comprehensive framework—emphasize notions of agency, autonomy, and substantive equality that engage with the emancipatory promise to advance gender justice. As a relatively new policy and advocacy space, menstrual health provides a unique opportunity to change entrenched patterns of marginalization" (Alhelou et al., 2022).

Moreover, the hygienist discourse may cause a disempowering effect on women. "The hygienist discourse had a significant presence in this first period of feminine protection, and the menstrual body was signified mainly as a problem for women's health because it was purportedly a source of disease. The reproductive body of bio-women in general was portrayed as delicate and inherently prone to disease, and the menstrual body portrayed as dirty and in need of cleaning" (Tarzibachi, 2022, p.62). One common refrain in initiatives focused on menstrual health and hygiene is the association of menstruation with stigma and shame (Olson et al., 2022, p.3). Additionally, the concept "hygiene" is loaded with regimes of ideologies pertaining to modernity and patriarchy (Bobel, 2018; Aengst et al., 2014). For instance, new industries are now competing over the meanings and market of the menstrual body (Tarzibachi, 2022, p.18).

"Following the diaper market, the feminine protection or feminine hygiene sector is the second largest global market in the disposable "hygiene" products category, mainly including sanitary pads, tampons, and panty liners (Euromonitor International, 2016). Globally, the United States (along with China) is the world's biggest femcare market (Euromonitor International, 2016). So great was the industry's consolidation at the international level that in 2015, its global sales totaled US$3 billion" (Tarzibachi, 2022, p.14-15). Pharmaceutical industry played a role in normalizing the menstrual body through control of analgesics (p.18). Product-focused menstrual management policies and the 'feminine hygiene sector'.[276] In this way, "menstrual hygiene management can be understood as compliance with the norm of menstrual concealment" (Wootton & Morison, 2020, p.4). [277]

[276] On one side, there are product-based sectors and pharmaceutical companies, which utilize female body for the companies' interest; while on the other side, there has also been a development of a product-focused approach within feminist activism. Product-based activism has been criticized from radical feminist approach: "Product-focused menstrual activism has shifted the movement from one that promotes a body-positive (or even body-neutral) embodied reality to one that prioritizes the efficient hiding of menstruation through increasing access to menstrual products" (Bobel & Fahs, 2020, p.956).

[277] "These practices represent an important part of the constant struggle to align with the standards of respectable femininity in Western societies (Bobel, 2019). Disciplining their unruly menstruating bodies through appropriate 'hygiene' practices is an important way that women demonstrate their respectability (Laverty, 2017), thereby securing entry into public spaces and participation in traditionally masculine endeavors (Young, 2005)." (Wootton & Morison, 2020, p.4)

To summarize, in this section, first the development approach and evaluation of global initiatives' development framework have been critically evaluated in terms of their approach to menstruation issue. Second, the emphasis on hygiene discourse has been critically evaluated. Consequently, the statement of WHO in 2022 for recognizing menstruation as a health issue rather than a hygiene issue is important, which may represent a shift in understanding. Moreover, the statement aims attention to menstrual health with its physical, psychological, and social dimensions, which need comprehensive attention throughout the various stages of life, from pre-menarche to post-menopause. To conclude, it can be said that menstrual-related health issues have not taken as much attention as menstrual hygiene had from a global perspective.

CHAPTER 6

CONCLUSION

This dissertation sought to explore why highly-educated, professional, middle-class, urban women prefer Traditional, Complementary, and Alternative Medicine (TCAM) methods either alongside or instead of biomedicine for their reproductive health conditions. Through in-depth interviews with women who have used TCAM and alternative healing practices, the research has revealed the transformative power of the lay perspective. The findings challenge the dominance of orthodox professional (expert) knowledge and highlight the significant ways women's experiences can redefine our understanding of reproductive health, particularly concerning menstruation-related conditions. The women in this study not only questioned and defied biomedical authority but also found success in managing reproductive health issues previously deemed incurable by biomedical experts. This underscores the need to reassess and broaden our comprehension of expert knowledge in reproductive health, recognizing the importance of lay knowledge in shaping health outcomes. By integrating the lived experiences and insights of these women, healthcare practices can become more effective, inclusive, and responsive to the real challenges women face.

From a theoretical perspective, this study critiques biological determinism and emphasizes the value of embodied experiences in understanding health and illness. While menstruation has traditionally been framed as a biological issue, cultural and social constructs have come to the forefront in modern studies. However, this thesis argues that menstruation—and by extension, women's reproductive health—should be understood within a framework that acknowledges its biological, psychological, social, and cultural dimensions. The use of George Engel's Biopsychosocial (BPS) model provided a comprehensive lens through which to analyze the treatment

processes of women’s reproductive health conditions. Despite the potential benefits of TCAM methods, the research also revealed a gap in systematic treatment protocols based on the BPS model. Women are often left to navigate their health issues through trial and error, with no structured approach guiding them. This creates vulnerabilities, leaving them open to mistakes or harm. To address this, there is a clear need for the development of treatment protocols that incorporate the BPS model and offer holistic, patient-centered care for women's reproductive health issues.

Additionally, themes of family dynamics, past traumas, societal pressures, and relational challenges emerged throughout the interviews. These issues—such as fears around relationships, difficulties in romantic or sexual interactions, and societal expectations of marriage and motherhood—were central to the healing journeys of the women interviewed. These findings further highlight the necessity for approaches to reproductive health that not only address physical symptoms but also consider psychological and emotional dimensions. The emotional release experienced during detoxification, as highlighted by Gabor Maté and Alice Miller, underscores the profound connection between emotional and physical health. Maté's (2019) concept of toxic stress, along with Miller's (2006) exploration of childhood trauma, illustrates how unresolved emotions can manifest as illness and how releasing these emotions is integral to healing. These insights align with the biopsychosocial framework, which emphasizes the interconnectedness of the mind, body, and emotions. Therefore, emotional release during practices like detox or breath work is not just incidental but essential to the overall healing process, as it allows the body and mind to process unresolved trauma and move towards holistic well-being. Northrup’s idea of the body as a repository for emotions and memories sets the tone for understanding healing as more than just physical treatment, it is deeply intertwined with emotional and psychosomatic factors, just conceptualized by Engel as BPS medical model (1977).

Drawing from Eastern traditions like Traditional Chinese Medicine and Ayurveda, the body and mind are seen as inseparable, with emotional experiences directly impacting physical health. Practices such as womb healing, yoni eggs, and yoni spa

treatments are rooted in the belief that reconnecting with the women's body and its wisdom can provide emotional and physical healing. The experiential nature of these practices, such as meditations, massages, and detoxes, helps individuals attune to their bodies and explore the emotional aspects of their health journey. Additionally, feminist scholars like Sullivan and Grosz emphasize embodiment as a key concept in understanding women's health. This involves recognizing the body as not just a biological entity but also a site shaped by social, cultural, and personal experiences. By engaging with practices that promote bodily awareness, women can address both emotional and physical dimensions of their health, moving beyond the limitations of biomedical approaches that often overlook these factors. My fieldwork highlights how these alternative healing practices are tied to a biopsychosocial model of health, recognizing the complex interactions between mind, body, and society. Practices such as abdominal massage, yoni massage, and dry brushing are not only aimed at physical healing but also at fostering emotional release and deeper self-connection. Through this lens, healing becomes an integrated process that empowers women to reclaim their bodily experiences. In Figure 5 present a graph for women's reproductive health in the BPS model. The graph is constructed based on data synthesized from theoretical perspectives outlined in the Chapter 3 on BPS model of Engel as well as the findings from my fieldwork.

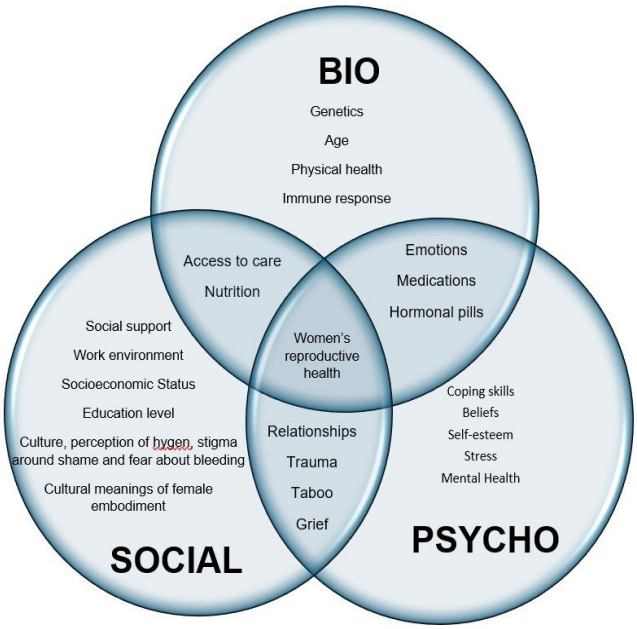

Figure 5. Women's Reproductive Health in the Biopsychosocial Model

The graph presented here is constructed based on data synthesized from theoretical perspectives outlined in the Chapter 3 of this thesis, as well as findings derived from fieldwork.

Moreover, this thesis argues that the exploration of the cyclical nature of the women body reveals insights into women's reproductive health and well-being. By recognizing the menstrual cycle as a series of interconnected phases, each with its own physical, emotional, and social dimensions, women can cultivate a deeper awareness of their embodied experiences. This awareness not only facilitates self-care practices but also fosters a holistic understanding of health that aligns with the BPS model. The integration of concepts like *Cycle Awareness* and the *Inner Seasons framework* emphasizes the need for women to honor their natural rhythms and adapt their lifestyles accordingly. As women navigate societal pressures that demand continuous productivity, aligning with their cyclical nature becomes an essential act of healing. The personal narratives shared by women in various healing practices highlight the transformative impact of recognizing and respecting their bodies' needs. This awareness enables women to enhance their physical and emotional health, mitigate the effects of societal expectations, and ultimately foster a more harmonious relationship with their bodies. Moreover, addressing issues like pelvic floor dysfunctions through an embodied lens acknowledges the interplay between biological, cultural, and social factors. This perspective challenges the reductionist views held in biomedicine and emphasizes the importance of understanding women's reproductive health within a broader context of lived experiences and societal norms.

In conclusion, the excerpts from the interlocutors from my fieldwork illustrate a holistic healing approach that intertwines the physical, social and emotional dimensions of health, aligning with the biopsychosocial (BPS) model. This shift in awareness reflects a growing recognition among women of the necessity to honor and care for their bodies, particularly in relation to their reproductive health and menstrual cycle. By exploring the root causes of health issues through a psycho-spiritual lens, these women confront their experiences of womanhood and past traumas, fostering a deeper connection with their bodies.

The participant observation of women's circles and online platforms in Türkiye highlights the vital role of community in addressing women's reprodcutive health and well-being through a biopsychosocial (BPS) lens. These gatherings not only facilitate the sharing of personal experiences but also create a supportive environment where women challenge cultural norms and explore their identities. The emotional and social dimensions of health are profoundly emphasized, as the participants engage in meaningful dialogues that foster solidarity and understanding. By recognizing their interconnectedness, women find empowerment and healing, transcending individual struggles that are unnoticed and unseen by biomedical model. Moreover, the integration of practices such as womb healing within these circles underscores the belief that individual well-being is inherently linked to the collective health of the community. This perspective aligns with the BPS model, which advocates for a holistic approach to health, considering the interplay of biological, psychological, and social factors. The emphasis on shared experiences in these sacred spaces not only nurtures personal growth but also contributes to a broader cultural transformation, reinforcing the importance of community in women's health. Ultimately, these circles exemplify how social support and collective empowerment are crucial for women's healing journeys, highlighting the necessity of fostering environments that honor and celebrate women's unique experiences and needs.

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APPENDICES

A. APPROVAL OF METU HUMAN SUBJECT ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

DUMLUPINAR BULVARI 06800
ÇANKAYA ANKARA/TURKEY
T: +90 312 210 22 91
F: +90 312 210 79 59
ueam@metu.edu.tr
www.ueam.metu.edu.tr

Sayı: 28620816 /

27 EKİM 2021

Konu : Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi : İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof. Dr. Ayşe Gündüz HOŞGÖR

Danışmanlığını yürüttüğünüz Tuğba ÖZCAN'ın "Kadın Hastalıkları Tanısı Konmuş Kadınların İyileşme Süreçlerinde Modern Tıp ve Alternatif/ Tamamlayıcı Tıp Yöntemleri Kullanımını Belirleyen Değişkenler" başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **436-ODTU-2021** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

Prof.Dr. Mine MISIRLISOY
İAEK Başkanı

B. VOLUNTARY PARTICIPATION FORM TO RESEARCH

ARAŞTIRMA GÖNÜLLÜ KATILIM FORMU

Bu çalışma, "Üreme Sağlığı Sorunları Yaşayan Eğitimli, Orta Sınıf, Profesyonel Kadınların İyileşme Süreçlerinde Modern Tıp ve Alternatif/ Tamamlayıcı Tıp Yöntemleri Kullanımını Belirleyen Değişkenler" başlıklı bir araştırma çalışması olup kadın sağlığı konusuna sosyolojik bir katkı sunma amacını taşımaktadır. Çalışma, Arş. Gör. Tuğba Özcan tarafından yürütülmekte ve ODTÜ SOSYOLOJİ BÖLÜMÜ bünyesinde yapılmaktadır. Bu çalışmaya katılımınız gönüllülük esasına dayanmaktadır.

- Çalışmanın amacı doğrultusunda, niteliksel mülakat görüşmeleri yapılarak sizden veriler toplanacaktır.
- İsminizi yazmak ya da kimliğinizi açığa çıkaracak bir bilgi vermek zorunda değilsiniz/araştırmada katılımcıların isimleri gizli tutulacaktır.
- Araştırma kapsamında toplanan veriler, sadece bilimsel amaçlar doğrultusunda kullanılacak, araştırmanın amacı dışında ya da bir başka araştırmada kullanılmayacak ve gerekmesi halinde, sizin (yazılı) izniniz olmadan başkalarıyla paylaşılmayacaktır.
- İstemeniz halinde sizden toplanan verileri inceleme hakkınız bulunmaktadır.
- Sizden toplanan veriler korunacak ve araştırma bitiminde arşivlenecek veya imha edilecektir.
- Veri toplama sürecinde/süreçlerinde size rahatsızlık verebilecek herhangi bir soru/talep olmayacaktır. Yine de katılımınız sırasında herhangi bir sebepten rahatsızlık hissederseniz çalışmadan istediğiniz zamanda ayrılabileceksiniz. Çalışmadan ayrılmanız durumunda sizden toplanan veriler çalışmadan çıkarılacak ve imha edilecektir.

Gönüllü katılım formunu okumak ve değerlendirmek üzere ayırdığınız zaman için teşekkür ederim. Çalışma hakkındaki sorularınızı Orta Doğu Teknik Üniversitesi Sosyoloji Bölümü'nden Tuğba Özcan'a (mail/tel) yöneltebilirsiniz.

Araştırmacı Adı : TUĞBA ÖZCAN

Adres : SOSYOLOJİ BÖL., B-39 /A ODTÜ 06800 ANKARA, TR

İş Tel : Cep Tel :

Bu çalışmaya tamamen kendi rızamla, istediğim takdirde çalışmadan ayrılabileceğimi bilerek verdiğim bilgilerin bilimsel amaçlarla kullanılmasını kabul ediyorum. (Lütfen bu formu doldurup imzaladıktan sonra veri toplayan kişiye veriniz.) Katılımcı Ad ve Soyadı: İmza: Tarih:

C. PERMISSION FROM PARTICIPANTS AND EXPLANATION FOR PARTICIPATION IN MY PhD THESIS RESEARCH

DOKTORA TEZI ARAŞTIRMAMA KATILIM IÇIN IZIN VE AÇIKLAMA

Ben Orta Doğu Teknik Üniversitesi Sosyoloji Bölümü doktora öğrencisi Tuğba Özcan.

Sağlık sosyoloji alanında doktora tezi hazırlıyorum. Araştırma konum kadın sağlığı ile alternatif ve tamamlayıcı tıp yöntemlerinin ilişkisi ve kadınların iyileşme deneyimleri üzerinedir.

Hazırlayacağım tezin konusu kendi hayatımda karşılaştığım sağlık sorunlarım ile ilişkili olarak doğdu. Menstrüasyon düzensizliği, regl ağrısı ve hormon dengesizliği sebebi ile yıllar boyu ziyaret ettiğim jinekoloji bölümünde tanısı konulamayan ağrılar sonrası hem modern tıp yöntemleri ile hem de geleneksel tıp ve alternatif terapiler ile iyileşme sürecinde adım adım ilerledim.

Sosyoloji bölümündeki çalışmalarım yüksek lisans yıllarından itibaren kadın odaklı oldu ve kadınlara iyi gelen bir şey yapmak istediğimi en derinde biliyordum. Ancak doktorada araştıracağım konunun, yıllardır içinde yaşadığım sağlık sorunları olacağını, yani burnumun dibindeki bir mesele olacağını tahmin etmemiştim.

Bu doktora araştırması kadın sağlığı sorunlarını modern tıp yanında alternatif ve bütünsel yöntemler kullanarak iyileştirme sürecinde olan ya da iyileştirmiş kadınları kapsayacaktır. Birebir niteliksel mülakat tekniği ile görüşmeler yapacağım. Bu görüşmeler sohbet şeklinde geçiyor ve bir-iki saat civarı sürüyor. Bu çalışma kadınların tanı sonrası yaşadıkları bedensel, duygusal, zihinsel ve ruhsal durumlar ve ilgili destek mekanizmaları, tedavi sürecinde yaşadıkları zorluklar ve çözüm yolları, ne tür tedavi yöntemleri kullandıkları ve nasıl faydalar gördükleri, yaşadıkları değişimleri ve tepkileri anlayabilmek adına yapılmaktadır.

Çalışmaya katkı sunmayı kabul eden katılımcılarla yaptığım görüşmelerin bilgileri tamamen gizli tutulacaktır. Verilen cevaplar kesinlikle ve sadece bir araştırma raporunda kullanılacak olup, isimler tarafımdan saklı tutulacaktır. Tez çalışmamı Prof. Dr. Ayşe Gündüz Hoşgör'ün danışmanlığında hazırlıyorum. Daha fazla kadına sağlık konusunda ışık olmasını amaçladığım bu çalışmaya katılım sağlamayı kabul ederseniz çok memnun olurum.

Dilerseniz bu konuda daha detaylı bilgi verebilirim. Desteğiniz beni çok mutlu eder.
Sevgilerimle,
Arş. Gör. Tuğba Özcan
Sosyoloji Bölümü / Sosyal Bilimler Enstitüsü
ORTA DOĞU TEKNİK ÜNİVERSİTESİ
06800 ANKARA, TÜRKİYE
İş telefon:
E-posta:
Cep Telefonu:

D. QUESTIONS OF IN-DEPTH INTERVIEWS IN TURKISH

DOKTORA TEZ ARAŞTIRMASINDA YAPILACAK MÜLAKATLAR İÇİN SORULAR

Adı:

Yaşı:

Medeni Durumu:

Çocuk Sayısı:

Eğitim Durumu:

Mesleği:

Gelir Miktarı:

1. Kendini tanıtır mısın?

Nerede yaşıyorsun?

İşin/mesleğin nedir?

Kaç yaşındasın?

2. Yaşamınızı anlatır mısınız? Hayat öyküsünde dönüm noktaların nelerdir?

3. Ergenliğe girdiğin zamanı nasıl hatırlıyorsun?

Kaç yaşındaydın?

Neler hissetmiştin?

Kimlerle paylaştın? Anlattın mı?

Önceden süreçle ilgili bilgin var mıydı?

4. Kadınlık süreçleri (regl /menarş, adet döngüsü, menopoz) hakkında bilgileri hangi kaynaklardan öğrendiniz? (Anne, teyze, TV, arkadaş sohbetleri, gazete& dergi vb.)

5. Kadın olmak sizin için neyi ifade ediyor?

6. Kadın sağlığı konusundaki ilk sorunların ne zaman başladı? Bu süreçte neler hissettiniz?

7. Fiziksel olarak ne gibi değişiklikler oldu?

8. Psikolojik olarak ne gibi değişikler yaşadınız?

9. Jinekologlar ile deneyimlerin nasıldı? Doktorlar sana nasıl davrandılar?

10. Doktorlara güveniyor musun?

11. İlaç kullandın mı? Şu an halihazırda ilaç kullanıyor musun?

12. İyileşme sürecinde neleri denedin?

13. İlaç tedavisi ve doktor reçetesi kullandın mı? İlaç tedavisi ve doktor reçetesi haricinde yöntemler kullandın mı? Detaylandırabilir misin?

14. Bu yöntemler hakkındaki bilgilere nasıl ulaştın? (TV, internet, kitap, dergi vs. aile, arkadaşlar, iş çevresi, hobi & sosyal çevre, sağlık çalışanları tavsiyesi vb.)

15. Alternatif ve geleneksel terapiler hakkında önceden ne düşünüyordun şimdi ne düşünüyorsun?

16. Bedenin ile ilişkin nasıl?

- Tedavi sürecinde kendi bedenin ile kurduğun ilişkide değişimler oldu mu?

17. İyileşmek deyince aklınıza neler geliyor? İyileşme sürecinde fikirlerinizde değişme oldu mu?

- Yaşam tarzınızda değişiklikler oldu mu? (Beslenme, diyet, spor, yeni hobiler vb.)

18. Deneyimlediğiniz sağlık problemleri ile sizi güçlü hissettiren durumlar oldu mu? Olduysa neler? (Kendin ile ilgili karar almak, hayatının gidişatında söz sahibi olmak, kendine değer vermek vb.)

19. Kadın hastalıkları yaşamanın, diğer hastalıklardan farkı nedir?

20. Anne ve teyzelerinizin kadın hastalıkları var mıydı? Onlar iyileşmek için neler yaptılar? Onların deneyimi ile kendi deneyiminizi nasıl karşılaştırırsınız?

21. Kadın hastalıkları yeteri kadar dile getiriliyor mu? Eğer az dile getiriliyorsa neden böyle olabilir?

22. Adet olmak, hamile kalmak, doğurmak, menopoza girmek sizin için ne ifade ediyor?

23. Sağlığınızdaki değişimler ile aile, eş, arkadaş ilişkilerinizde bir fark oldu mu?

24. İş yaşamı ve ev içi sorumluluklarınız ile sağlığınız arasında bir ilişki olduğunu düşünüyorsunuz? Hastalığı fark etmeniz ve iyileşme süreciniz ile bu ilişkide değişiklikler oldu mu?

25. İyileşme süreci sonrası sağlığınız hakkında endişeleriniz arttı mı?

26. "Her kadın kendinin şifacısıdır" sözü hakkında ne düşünüyorsunuz?

TEŞEKKÜR EDERİM

ARŞ.GÖR. TUĞBA ÖZCAN

E. QUESTIONS OF IN-DEPTH INTERVIEWS

Demographic Information:

Name:

Age:

Marital Status:

Number of Children:

Education Level:

Occupation:

Income Level:

1. Can you introduce yourself?

1.1. Where do you live?

1.2. What is your job/profession?

1.3. How old are you?

2.Could you narrate your life? What are the turning points in your life story?

3.Can you recall entering adolescence?

3.1. How old were you?

3.2. What did you feel?

3.3. Whom did you share it with? Did you talk about it?

3.4. Did you have prior knowledge about this process?

4. What sources provide you information about women's health processes (menstruation/menarche, menstrual cycle, menopause)? (Mother, aunt, TV, conversations with friends, newspapers & magazines, etc.)

5.What does being a woman mean to you?

6.When did your initial health issues related to womanhood begin? What did you feel during this process?

7.What physical changes occurred?

8.What psychological changes did you experience?

9.How were your experiences with gynecologists? How did doctors treat you?

10.Do you trust doctors?

11.Have you used medication? Are you currently taking any medication?

12.What did you try during the healing process?

13.Have you used medication prescribed by doctors? Have you used methods other than medication and doctor-prescribed treatments? Can you elaborate?

14. How did you access information about these methods? (TV, internet, books, magazines, family, friends, work environment, hobbies & social circles, recommendations from healthcare professionals, etc.)

15.What were your previous thoughts on alternative and traditional therapies, and what are your thoughts now?

16.How is your relationship with your body?

16.1. Did your relationship with your body change during the treatment process?

17.When you think about healing, what comes to your mind? Have your ideas about healing changed during the healing process?

17.1. Have there been any changes in your lifestyle? (Diet, exercise, new hobbies, etc.)

18.Were any instances of health problems you experienced that made you feel strong? If yes, what were they? (Making decisions about yourself, having a say in the course of your life, self-worth, etc.)

19.What distinguishes experiencing women's health problems from other health issues?

20. Did your mother or aunts have women's health problems? What did they do to recover? How do you compare their experiences with yours?

21. Are women's health problems adequately discussed? If not, why might that be?

22.What do menstruation, getting pregnant, giving birth, and menopause mean to you?

23.Have there been any changes in your family, spouse, or friend relationships due to changes in your health?

24.Do you think there is a relationship between your work life, household responsibilities, and your health? Have there been any changes in this relationship regarding noticing the illness or the recovery process?

25.Have your concerns about your health increased after the healing process?

26.What do you think about the saying, "Every woman is her own healer"?"

F. INTERNATIONAL CLASSIFICATION OF DISEASES (ICD-10) OF THE WHO.

Pain and other conditions associated with female genital organs and menstrual cycle N94
● Short description: Unsp cond assoc w female genital organs and menstrual cycle
● The 2024 edition of ICD-10-CM N94.9 became effective on October 1, 2023.
● This is the American ICD-10-CM version of N94.9 - other international versions of ICD-10 N94.9 may differ.
ICD-10-CM Coding Rules
● N94.9 is applicable to female patients.

ICD-10-CM Codes › N00-N99 › N80-N98 › Pain and other conditions associated with female genital organs and menstrual cycle N94

Pain and other conditions associated with female genital organs and menstrual cycle N94-Codes

N94 Pain and other conditions associated with female genital organs and menstrual cycle

N94.0 Mittelschmerz

N94.1 Dyspareunia

N94.10 Unspecified dyspareunia

N94.11 Superficial (introital) dyspareunia

N94.12 Deep dyspareunia

N94.19 Other specified dyspareunia

N94.2 Vaginismus

N94.3 Premenstrual tension syndrome

N94.4 Primary dysmenorrhea

N94.5 Secondary dysmenorrhea

N94.6 Dysmenorrhea, unspecified

N94.8 Other specified conditions associated with female genital organs and menstrual cycle

N94.81 Vulvodynia

N94.810 Vulvar vestibulitis

N94.818 Other vulvodynia

N94.819 …… unspecified

N94.89 Other specified conditions associated with female genital organs and menstrual cycle

N94.9 Unspecified condition associated with female genital organs and menstrual cycle

Information taken from: https://www.icd10data.com/ICD10CM/Codes/N00-N99/N80-N98/N94-

G. CURRICULUM VITAE

Personal Information

Surname, Name: Özcan, Tuğba

Nationality: Turkish (TC)

Date and Place of Birth:

Phone:

email:

Education

2015-2024 PhD, Sociology Department, METU. **(Ankara, Turkey)**

Thesis title: Higly Educated and Professional, Middle Class Women with Reproductive Health Problems between Biomedicine and Complementary and Alternative Medicine: A Case Study in Türkiye

Supervisor: Prof. Dr. Ayşe Gündüz Hoşgör

2011-2015 MSc, Sociology Department, METU. **(Ankara, Turkey)**

Thesis title: The Ambivalent Political Agency of Intellectual Religious Women in Turkey: A Case Study of the Abortion Debate in 2012

Supervisor: Dr. Barış Mücen

2010-2011 Scientific Preparation, Sociology Department, METU. **(Ankara, Turkey)**

2006-2010 BA, Department of Foreign Language Education, METU.

Major: English Language Teaching (Grad. CGPA: 3.44 /4)

2007-2010 BA, Department of Foreign Language Education, METU.

Minor: History of Philosophy (completed 62 ECTS)

2008-2019 Visiting Student, **INHOLLAND University (Rotterdam, The Netherlands)**

Minor: International Teacher Training Education

2005-2006 BA, Department of Computer Education and Instructional Technology, METU.

Completed one year of study in Computer Sciences, before pursuing to FLE.

2000-2004 High School: **Ankara Ataturk Anatolian High School**

Work Experience

09/2014 – 09/2022

Research t and Teaching Assistant, **Sociology Department**

Middle East Technical University, Ankara, Turkey

08/2013 – 09/2014

Research Assistant and Lecturer, Sociology Department

Batman University, Batman, Turkey

09/2012 – 12/2013

Project Assistant

TUBITAK Project: Urban Transformation and Displacement Experiences in the Northern Ankara Entrance Urban Transformation Project (NAEUTP).

Supervisor: Doç. Dr. Tahire Erman Bilkent University | Ankara, Turkey

05/2011 – 06/2011

Research Assistant at GAP Project: Privatization and Its Impact on Business Processes, The Case of Lignite Coal Enterprises. Mining workers in Kütahya, Turkey

Supervisor: Assoc. Prof. Sibel Kalaycıoğlu, METU | Ankara, Turkey

10/2008 – 01/2009

Researcher at METU Project: The Case of Domestic Women Workers in Dikmen | Ankara Turkey

CONFERENCE ORGANIZATION

Member of the Organizing Committee of the conference "Challenging Rural Studies in Turkey: present state and new imaginaries" co-organized by the Department of Sociology of Middle East Technical University and the European Society of Rural Sociology. June 23-24, 2022, Ankara, Turkey.

AWARDS AND SCHOLARSHIPS

10/2010 – 10/2012: **Scientific and Technological Research Council of Turkey (TUBİTAK)**

(Ms) 2211-Domestic Postgraduate Scholarship Program

10/2014 – 10/2018: **Scientific and Technological Research Council of Turkey (TUBİTAK)**

(Phd.) 2211-Domestic Phd. Scholarship Program

12/2008 – 06/2009: **ERASMUS Scholarship of the European Union**

Undergrauate Study at InHolland University- Rotterdam, The Netherlands

INTERNSHIP

02/2010 – 06/ 2010 **English Teacher**

Dr. Binnaz Ege- Dr. Rıdvan Ege Anatolian High School | Ankara, Turkey

04/2009 – 06/ 2009 **English Teacher**

De Blijberg International School **|** Rotterdam, The Netherlands

02/2009 – 06/ 2009 **English Teacher**

Prinses Margriet School **|** Rotterdam, The Netherlands

ACADEMIC SKILLS TRAINING and SKILLS

06/2013 – 02/ 2014, **Nvivo Version 10,** Qualitative Data Analysis (QDA) Computer Software,

Introductory Hands-on Workshop Certificate

12/2019 – 02/ 2020, **MAXQDA** Qualitative Data Analysis (QDA) Computer Software. Workshop

08/2011 – 09/2011, AFEM Summer School 2011, International Summer School for Students of Social Sciences on Psychosocial Support and Vulnerable Groups in Disasters and Emergencies. European Natural Disasters Training Center (AFEM) of Turkey.

H. TURKISH SUMMARY / TÜRKÇE ÖZET

Bu tez, Türkiye'deki yüksek eğitimli, profesyonel, orta sınıf kadınların üreme sağlığına yönelik alternatif ve geleneksel tıp kullanımını incelemektedir. Çalışmanın amacı, biyomedikal yöntemlere erişim imkânı olmasına rağmen kadınların neden geleneksel ve alternatif tıp yöntemlerine yöneldiğini ve bu uygulamaların bedensel, psikolojik ve sosyal alanlarda neler sunduğunu anlamaktır. Tezin önemi, kadınların üreme sağlığına dair tarihsel ve güncel yaklaşımları eleştirel bir perspektiften ele alarak, genellikle göz ardı edilmiş olan kadın üreme sağlığına radikal feminist bir bakış açısıyla yaklaşmasıdır. Kadın üreme sağlığını, özellikle gelişmekte olan ülkelerde nüfus kontrolü için bir araç olarak gören kalkınma politikalarını ve 'hak'anlatısı çerçevesindeki 'tercih odaklı' liberal modeli sorgulayarak yeniden düşünmeyi amaçlamaktadır.

Araştırma, Türkiye'nin farklı şehirlerinden 18 kadınla yapılan derinlemesine görüşmeler ve katılımcı gözlem yöntemlerine dayanan nitel bir çalışma ile gerçekleştirilmiştir. Bulgular, kadınların geleneksel tıp yöntemlerini tercih etmelerinin temelinde modern sağlık sistemine duyulan güvensizlik, uzun süren tedavi süreçlerinden sonuç alamama ve doktor-hasta ilişkisindeki cinsiyetçi yaklaşımların yer aldığını göstermektedir. Kadın üreme sağlığı sorunlarının yalnızca biyolojik değil, aynı zamanda psikolojik ve sosyal boyutlarıyla ele alınmasının önemi üzerinedir. Bu çalışma, Türkiye'de kadınların üreme sağlığı temelli, geleneksel ve alternatif tıp kullanımı hakkında önemli ve yeni bulgular sunarak; sosyal ilişkiler, kadın dayanışması, kolektif bilinç ve kadın bedenlenmesi (embodiment) üzerine yeni tartışmalar açmıştır.

Günümüzde farklı yaş grubundaki kadınlar, üreme sağlığı sorunlarıyla karşı karşıya kalmaktadır. Kadın bedeni ve sağlığı, tarihsel olarak biyomedikal alanda tartışmalı bir konu olduğu gibi sosyolojik açıdan da incelenmeye değerdir. Dünya Sağlık Örgütü'nün (DSO) 2019 tarihli raporuna göre, Geleneksel, Tamamlayıcı ve Alternatif

Tıp (GTAT) kullanımının Batı ülkelerinde arttığı gözlemlenmiştir (Mortada, 2024; Eisenberg et al., 1993). Kadınların, erkeklere oranla GTAT yöntemlerine daha sık başvurduğu bilinmektedir (Eardley et al., 2012; Rayner et al., 2011; Tindle et al., 2005; Verhoef et al., 2005; Ernst & White, 2000; Beal, 1998; Sharma, 1995). Kadınların üreme sağlığı, geleneksel tıp ve yeni gelişen alternatif terapilerin kullanımındaki yükselen eğilimi anlamak açısından kilit bir örnek teşkil etmektedir (Rayner et al., 2011; Beal, 1998). Bu tezde, kadınların üreme sağlığı, özellikle regl ile ilgili rahatsızlıklar üzerinden kadınların sağlık arayışlarındaki tercihleri ile biyomedikal ve bütüncül sağlık modelleri arasında kurulan ilişkiyi incelemeyi amaçlıyorum.

Kişisel sağlık yolculuğum, bu konuyu akademik olarak çalışmamda önemli bir etken oldu. 16 yaşından 33 yaşıma kadar, adetle ilgili sorunlarım için birçok jinekoloğa başvurdum. Başlarda, ağır regl ağrıları yaşadım ve Majesik adlı ağrı kesiciyi 4-5 yıl boyunca düzenli olarak kullandım. 20'li yaşlarımda Polikistik Over Sendromu (PKOS) ve Premenstrüel Sendrom (PMS) tanısı aldım. Yorgunluk, karın ağrısı, bel ağrıları ve beyin sisi gibi belirtilerle uzun yıllar mücadele ettim. Beş yıl boyunca doğum kontrol hapları kullandım, ancak bu tedavi semptomlarımı hafifletmek yerine daha da ağırlaştırdı.

Birçok doktorun, şiddetli ağrılarımın ve PMS'in evlilik veya doğumla çözülebileceğini söylemesi, beni derin bir arayışa sürükledi. Doktorların çoğu bu ağrıları 'normal' olarak değerlendirse de, hislerim bunun böyle olmadığını söylüyordu. 2016 yılında, bir arkadaşımın tavsiyesiyle geleneksel Çin tıbbı ve modern biyomedikal yaklaşımları birleştiren Dr. Elif Selek'e başvurdum. Bu tedavi süreci hayatımda önemli değişiklikler yarattı ve 2017-2018 yıllarında yaşam tarzımı ve beslenme alışkanlıklarımı tamamen değiştirdim. Zorlu bir süreç olmasına rağmen, bu doğal tedavi benim için işe yaradı ve hormonal sorunlarım için kimyasal ilaçları tamamen bıraktım. Bu süreç, hem sağlık durumumu anlamamayardımcı oldu hem de bu konuyu akademik olarak araştırma isteğimi artırdı.

2019 yılına geldiğimde tedavi sürecim büyük ölçüde sağlığımı iyileştirmişti: regl döngüm düzene girmiş, polikistik over geçmiş ve ağır karın ağrılarım azalmıştı. Bu

dönüşüm, doktorlardan sürekli duyduğum ‘evlilik’, ‘doğum’ ve ağrı kesici reçetelerinin ötesinde gerçek çözümler olduğunu fark ettirdi. Bu süreçte benim gibi kaç kadının yıllarca doktor kapılarında beklediğini, ağrılarının çözülemez olduğuna inandığını ve acı çekmeye devam ettiğini merak etmeye başladım. Kendi deneyimlerimi ve benzer durumlardaki birçok kadının karşılaştığı daha geniş zorlukları düşündüğümde, kadınların üreme organlarının ve adet sağlığının karmaşıklıklarını daha derinlemesine araştırma ihtiyacı hissettim. Bu kişisel iyileşme yolculuğu sadece merakımı körüklemekle kalmadı, aynı zamanda araştırma odağımı da yönlendirdi.

Kendi deneyimlerim ve saha araştırmalarım sırasında gözlemlediğim çeşitli alternatif tedavi yöntemleri, bazen kadınların sağlıklarına zarar verebilecek sonuçlar doğurabiliyordu. Bu da beni, denediğim yöntemler konusunda daha temkinli olmaya yönlendirdi. Bazı GTAT yöntemlerinden büyük faydalar sağlasam da, enerji temelli şifa tekniklerine karşı hâlâ şüphelerim var. Bu şüpheler ve denediğim çeşitli alternatif terapiler, araştırma sürecimin hem kişisel hem de akademik olarak gelişmesine katkı sağladı.

Şifa yolculuğum sırasındaki deneyimlerime ve uygulamalarıma dayanarak, birçok TCAM yönteminden faydalandığımı güvenle söyleyebilirim. Çin ve Japon akupunkturu, ozon terapisi, kupa (hacamat), sülük terapisi (sülük), osteopati, mıknatıs terapisi, bitkisel ilaç, müzik terapisi ve Qi Gong konusunda uzmanlaşmış olanlar da dahil olmak üzere çeşitli TCAM uygulayıcılarından tedavi aradım. Ayrıca, 'Kadın Şifa Sanatları', refleksoloji, yoga, meditasyon ve Ayurveda gibi alanlarda eğitim aldım. Kitap okumak, videolar izlemek, seminerlere katılmak ve beden ve zihin sağlığına odaklanan kurslar almak gibi bir dizi kaynağa daldım.

Bu tez, üreme sağlığı sorunları yaşayan, yüksek eğitimli, profesyonel, orta sınıf kadınların modern biyomedikal tedavilere erişimlerine rağmen Nitelikli, Geleneksel ve Tamamlayıcı Alternatif Tıbbı (GTAT) neden tercih ettiklerini incelemektedir. Sosyolojik bir bakış açısıyla, üreme sağlığının kadınlar için neden bu kadar önemli olduğu ve birçok kadının biyomedikal çözümlerden neden memnun kalmadığı sorularını ele almaktadır. Çalışma, kadınların üreme sağlığının sadece tıbbi değil,

aynı zamanda sosyolojik açıdan da önemli olduğu ve alternatif tedavi arayışlarının biyomedikal tıbbın güçlü ve sınırlı yönlerini ortaya koyduğu, dolayısıyla feminist bir değerlendirme gerektirdiği varsayımlarına dayanmaktadır.

Araştırma Soruları:

1. Üreme sağlığı sorunları olan yüksek eğitimli, profesyonel, orta sınıf kadınlar, biyomedikal hizmetler mevcut olmasına rağmen neden GTAT'ı tercih etmektedir?
2. Bu kadınların GTAT yöntemleriyle ilgili öznel deneyimleri nelerdir ve iyileşme süreçlerini nasıl algılamaktadırlar?

Araştırma Amaçları:

1. Kadınların GTAT tercihlerini anlamak.
2. Biyomedikal ve biyopsikososyal sağlık modelleriyle ilgili deneyimlerini incelemek.
3. Tercihlerinin, sağlık hizmeti kararlarını ve bedenlerine dair algılarını nasıl şekillendirdiğini keşfetmek.

Kapsam ve Gerekçe: Bu araştırma, yüksek eğitimli, profesyonel, orta sınıf kadınların karar verme süreçlerini ve tedavi deneyimlerini analiz etmeyi amaçlamaktadır.

Tıp ile kadın bedeni arasındaki ilişki, özellikle medikalleşme bağlamında uzun zamandır eleştirin odağında yer almaktadır. Medikalleşme, tıbbi olmayan sorunların tıbbi problemler olarak çerçevelenmesini ifade eden bir kavramdır ve kadın bedeninin biyomedikal müdahaleler yoluyla kontrol ve düzenlemeye tabi tutulma sürecini anlamada kritik bir bakış sunmaktadır (Conrad, 1992; Zola, 1972; Illich, 1976). Bu bağlamda, Foucault'nun bilgi ve iktidar ilişkileri üzerine yaptığı çalışmalar, tıbbın yalnızca bireysel hastalıkları değil, aynı zamanda toplumsal normları ve güç yapılarını nasıl şekillendirdiğini göstermektedir (Foucault, 1973). Özellikle kadınların üreme sağlığı, medikalleşme süreci içinde tıbbın toplumsal kontrol araçlarından biri haline gelmiştir (Kennedy & Kennedy, 2010). Feminist eleştiriler, modern tıbbın patriyarkal yapılar içinde kadın bedenini kontrol altına alarak doğal süreçleri, örneğin doğum ve menopozu, tıbbi müdahale gerektiren

patolojiler olarak yeniden tanımladığını vurgular (Ehrenreich & English, 1973; Du Rose, 2015). Kadınların üreme sağlığı alanında medikalleşme ve farmasötikleşme süreçleri, kadınların özerkliğini sınırlayan ve bedenleri üzerindeki kontrolü azaltan mekanizmalar olarak ele alınmaktadır (Chrisler, 2004). Bu süreçler, yalnızca kadınların tıbbi sistemlere bağımlı hale gelmesine değil, aynı zamanda bedenleri üzerindeki toplumsal baskının artmasına da neden olmaktadır (Prosen & Krajnc, 2019).

Farklı feminist perspektifler, liberal, radikal, Marksist ve ekofeminizm gibi, patriarkanın erkek egemenliğine dayanan bir güç sistemi olarak işlediği konusunda hemfikirdir, ancak kadınların baskı altına alınışını açıklamada farklılık gösterirler. Radikal feminizm özellikle adet görmenin tıbbi hale getirilmesini eleştirir; bu süreçlerin doğal olarak patolojileştirildiğini ve kadın bedenleri üzerinde kontrol kurarak kurumsal patriarkayı pekiştirdiğini savunur. Bu tıbbi hale getirme, özellikle adet ürünleri ve doğurganlık tedavilerinin ticarileştirilmesi yoluyla, genellikle kadınların özerkliğini zayıflatır; çünkü sağlık sistemleri ve profesyoneller, üreme kararları üzerinde otorite kurar (Aengst & Layne, 2013; Delaney et al., 1977; Martin, 1987).

Bu tez, kadınların üreme sağlığının özellikle gelişmekte olan ülkelerde tarihsel olarak nüfus kontrolü amacıyla kullanılması olgusuna eleştirel bir şekilde yaklaşmaktadır. Kadınların doğurganlık oranlarını sınırlamaya yönelik bu yaklaşımlar sorgulanmaktadır (Morison, 2021; Hartmann, 2016; Wang & Pillai, 2001). 1994 Uluslararası Nüfus ve Kalkınma Konferansı (ICPD) ile üreme haklarının insan hakkı olarak tanınması süreci başlamış olsa da, mevcut modellerin feminist ideallerin tam olarak hayata geçirilmesindeki sınırlılıklarına da dikkat çekilmektedir (Pollack Petchesky, 1995). Bu çalışma, üreme sağlığına dair dar nüfus kontrolü odaklı yaklaşımları eleştirip, kadınların özerkliğini ve sosyo-politik bağlamları içeren daha kapsamlı bir anlayışı savunmayı amaçlamaktadır.

Araştırma Metodolojisi

Bu araştırma, iyi eğitimli, profesyonel ve orta sınıf kadınların üreme sağlığı deneyimlerini incelemek için feminist bir metodoloji benimsemektedir. Bu bölüm,

feminist bir bakış açısından kadın sağlığı araştırmalarında nitel yöntemlerin önemini vurgulayarak başlamaktadır (Henwood & Pidgeon, 1994; Murray & Chamberlain, 2000).

Charmaz (2002), tıp sosyolojisinin tarihsel olarak epidemiyolojik çalışmalar ve hastalık deneyimlerine odaklandığını belirtir. Genellikle nicel olan epidemiyolojik araştırmalar, hastalıkların yayılım kalıplarını ve risk faktörlerini ortaya çıkarmayı amaçlar. Buna karşın nitel yaklaşımlar, hastalığın öznel deneyimlerini, sosyal bağlamı ve bireylerin başa çıkma mekanizmalarını vurgular. Kadın sağlığı araştırmalarında nitel yöntemlerin kullanımı artmış ve daha fazla araştırmacı kontekstüalist ve inşacı yaklaşımları benimsemiştir (Murray & Chamberlain, 2000). Tıbbi araştırmalar neden-sonuç ilişkilerine odaklanırken, sosyoloji daha geniş sosyal sonuçları inceler. Harding (1987), metodolojinin araştırmayı yönlendiren bir teori olduğunu, epistemolojinin ise bu metodolojiyi temellendiren bilgi teorisi olduğunu vurgular.

Nitel yöntemler, kadın sağlığı araştırmalarında öznel deneyimleri, toplumsal ve kültürel bağlamların etkisini ve katılımcıların anlatılarındaki çelişkileri yakalayabilmesi sayesinde önemlidir (Olesen vd., 1997). İlk olarak, bu yöntemler, genellikle nicel araştırmaların göz ardı ettiği bireysel perspektiflere öncelik verir; çünkü nicel araştırmalar genelleme yaparak bulguları risk altına sokma potansiyeli taşırken, azınlık grupların deneyimlerini görünmez hale getirebilir (Freedman, 1998). Siyah feministler, siyah kadınların sağlık araştırmalarındaki yetersiz temsilini eleştirerek, bu eksikliğin tıbbi uygulamalarda eşitsizlikleri devam ettirdiğini savunmuşlardır (Freedman, 1998; Brawley, 1994). Cinsiyet yanlılığı, erkek bedenlerinin referans alınmasıyla kadın sağlığı sorunlarının yetersiz anlaşılmasına da yol açmaktadır. Örneğin, koroner kalp hastalıklarıyla ilgili çalışmalar bu duruma örnektir (Daugherty vd., 2017). ‘Cinsiyet tıbbı’ kavramı, bu farklılıkları kabul eder ve biyolojik ve toplumsal etmenlerin kadın ve erkeklerde sağlığı nasıl farklı etkilediğini incelemeye odaklanır (Regitz-Zagrosek & Gebhard, 2022).

İkinci olarak, nitel araştırmalar sağlık ve hastalığı toplumsal ve kültürel bağlamları içinde incelemeyi mümkün kılar, bu deneyimlerin sabit olmayıp toplumsal çevreler

tarafından dinamik bir şekilde şekillendiğini vurgular (Radley, 1999). Mauthner (1998) örneğin, doğum sonrası depresyonu, kadınların kendileriyle ve başkalarıyla olan ilişkileri bağlamında ele alır ve sosyal yapılar tarafından nasıl şekillendiğini gösterir. Üçüncü olarak, nitel yöntemler, katılımcıların inanç ve eylemlerindeki çelişkileri anlamaya olanak sağlar. Örneğin, Bransen'in (1992) menstruasyon üzerine yaptığı çalışma, tıbbi söylemin kadın bedenine mutlak bir güç uyguladığı görüşüne karşı çıkarak, kadınların kendi bedenlerine dair çeşitli anlamlar ürettiklerini göstermektedir. Son olarak, nitel yöntemler daha esnek, katılımcı bir araştırma yaklaşımı sağlar. Bu yöntemler, araştırmacı ile katılımcı arasındaki geleneksel güç hiyerarşilerini sorgulayarak katılımcılara kendi perspektiflerini paylaşma imkânı tanır (Lawless, 1993). Bu feminist yaklaşım, araştırmacı ile katılımcı arasında eşit bir iş birliği ortamını teşvik eder (Beckman, 2014; Malterud & Hollnagel, 1998).

Türkiye bağlamında, kadınların üreme sağlığı üzerine yapılan araştırmaların büyük kısmı tıp ve hemşirelik alanlarında yapılmış olup, sosyolojik araştırmalar sınırlıdır. Tezim, üreme sağlığı konusunda kadınların deneyimlerini derinlemesine görüşmeler ve katılımcı gözlem yoluyla inceleyerek bu boşluğu doldurmayı amaçlamaktadır. Kadınların üreme sağlığı üzerine olan bu tez, radikal bir feminist bakış açısıyla ele alınarak üreme organlarının ve kapasitelerinin yalnızca nüfus kontrolü veya doğurganlık üzerinden değerlendirildiği yaygın görüşe eleştirel bir yaklaşım sunmaktadır. Bu çalışma, üreme adaleti çerçevesi ilkelerini izleyerek kadınların üreme sağlığının onların genel refahı ve özerkliği için temel bir unsur olduğunu savunmaktadır (Morison, 2021, s. 180). Sosyolojik çalışmalar, 1970'ler ve 1980'lerde kadın sağlığını çoğunlukla üreme biyolojisiyle ilişkilendirmiş ve doğum, doğum kontrolü, kürtaj ve kısırlık gibi hizmetlere odaklanarak kadın sağlığının diğer yönlerini ihmal etmiştir (Doyal, 1995). Sosyal bilimler literatürü, genellikle üreme sağlığına dair iki analitik çerçeve kullanmaktadır: Birincisi sosyoekonomik durum ve sağlık hizmetlerine erişim gibi toplumsal yapısal faktörleri incelemekte, ikincisi ise halk sağlığı bağlamında üreme haklarını ele almaktadır (Wang & Pillai, 2001, s. 232). Mevcut araştırmaların önemini kabul etmekle birlikte, bu tez, bu geleneksel perspektifleri eleştirel bir şekilde değerlendirmektedir. Aynı zamanda, menstruasyon gibi genellikle damgalanmış ve utanma duygusuyla çevrili olan konuların sınırlı bir şekilde ele alındığını vurgulamaktadır (Olson et al., 2022; Bobel & Fahs, 2020).

Radikal feminist bir çerçeve kullanılarak, bu çalışma, kadınların üreme sağlığını onların bütünsel sağlıklarının merkezine yerleştirmektedir.

Alan Araştırması

Kadınların araçsallaştırılmasını önlemek ve güçlü bir bağ kurmak araştırmamın temel önceliklerindendir. Bu nedenle, potansiyel katılımcılara davet göndermeden önce özenle yaklaştım. Örneğin, katılımcıların üreme sağlığı sorunları hakkında biraz bilgi sahibi olmama rağmen, bu konuları konuşmaya ne kadar açık olduklarını anlamak için kendimi ve araştırmamı tanıttım ve bu bağlamda sosyal bir araştırma projesine katkı sağlamanın uygun olup olmadığını sordum. Bazı katılımcılarla arkadaşlık ilişkisi kurarak, onların günlük yaşamlarına dahil oldum; yoga ve meditasyon kamplarında vakit geçirdik ve aynı eğitim programlarına katıldık. Örneğin, Kadınların Şifa Sanatları Eğitimi gibi programlarda sınıf arkadaşı olarak birlikte öğrenme ve pratik yapma sürecimiz oldu. Bu şekilde, yaklaşık 2-3 yıllık bir süre boyunca doğal bir şekilde kardeşlik ilişkisi geliştirdik.

Bu çalışmada, kadınların algıları temel olduğu için nitel araştırma yöntemleri kullanılarak birincil veriler toplandı ve bu, yarı yapılandırılmış derinlemesine görüşmelerle yürütüldü (Davies, 2007). Her aşamada feminist metodoloji yaklaşımları ve teknikleri kullanıldı. Verilerin üretilmesi sürecinde farklı yöntemler kullanıldı. Görüşmelere başlamadan önce Haziran 2019 ile Aralık 2020 arasında akademik makaleler ve tezler gibi bilimsel literatür incelendi. Ancak, literatür taraması saha çalışması sürecinde topladığım verilerle birlikte evrildi ve şekillendi. Charmaz'ın (2006) belirttiği gibi, literatür taraması statik bir süreç değildir; verilerden yeni içgörüler elde edildikçe gözden geçirilir ve teorik çerçeve derinleştirilir. Araştırmanın ilk aşamasında, 2019 yılında, 5 katılımcı ile pilot çalışma gerçekleştirildi ve bu aşamada derinlemesine görüşmelerin araştırma sorularına nasıl anlamlı bir açıklama sağlayabileceği keşfedildi. Covid-19 pandemisi nedeniyle bazı gecikmeler olsa da, saha araştırması 2021 sonunda başlatıldı.Veri toplama sürecinde birebir derinlemesine görüşme teknikleri ve saha çalışmasında gözlemsel veriler toplama yöntemleri kullanılmıştır.

Yarı yapılandırılmış bir formatla esneklik sağlanarak, temel konular ele alınmıştır. Görüşmelerin ana başlıkları kişisel sağlık geçmişi, biyomedikal tedavi deneyimleri,

TCAM deneyimleri, TCAM'ı tercih etme nedenleri ve genel sağlık durumları üzerinedir Charmaz'ın (2006) yoğun görüşme yaklaşımı takip edilmiştir. Bu yöntem, katılımcılarla "yönlendirilmiş konuşmalar" aracılığıyla derinlemesine keşif imkanı sunar. Açık uçlu ve yargısız sorularla spontane ve özgün anlatılar teşvik edilmiştir. Toplamda 18 görüşme Kasım 2021 ve Mart 2023 tarihleri arasında, her biri 1,5 ile 3 saat arasında süren görüşmeler gerçekleştirilmiştir. Kar topu örnekleme yöntemi kullanılmıştır (Storey & Scheyvens, 2003).

Aynı zamanda, kadınlarla paylaşım ve deneyimlerin derinlemesine incelendiği, TCAM uygulamalarının yapıldığı kliniklerde ve kadınlara özel mekanlarda gözlem yapılmıştır. Ayrıca, sosyal ağlar ve online platformlarda kadınların menstrüasyon, PCOS destek grupları, rahim bilimi ve kadın çemberi pratikleri üzerine paylaşımları takip edilmiştir. Bu platformlar, kadınların kişisel hikayelerini paylaştıkları zengin örnekler sunmuştur. Cotterill'in (1992) belirttiği gibi, feminist araştırmada kadın araştırmacıların öznel deneyimlerinin bilgiyi üretmede önemli bir rolü vardır. 2018-2023 yılları arasında katıldığım birçok rahim iyileştirme seansı, meditasyon inzivaları, kadın çemberleri ve yoga kampları, benzer düşüncelere sahip kadınların iyileşme yolculuklarına tanıklık etmem için değerli bir gözlem ortamı sağlamıştır.

Tez saha çalışmasında demografik bilgiler, Türkiye'nin farklı şehirlerinden (Ankara, Antalya, Balıkesir, Bartın, Eskişehir, İstanbul, İzmir, Muğla, Trabzon) 18 kadını kapsamaktadır. Kadınların medeni durumları bekâr, evli, boşanmış ve dul olarak çeşitlenmekte olup, bazılarının çocukları varken (bebeklerden yetişkinlere kadar), diğerlerinin yoktur. Katılımcılar mühendislik, eğitim, bankacılık, sağlık ve akademi gibi farklı mesleklerden gelmektedir. Birçoğu ise nefes koçluğu, yüz yogası eğitmenliği, holistik uygulayıcılık ve takı tasarımı, fonksiyonel tıp ve kadın sağlığı eğitimi gibi alanlarda girişimciliğe geçiş yapmıştır.

Teorik Çerçeve

Hipokrat'tan bu yana sağlık, bedenin uyum ve dengesinin korunması olarak tanımlanmış, bu denge bozulduğunda hastalıkların ortaya çıktığı vurgulanmıştır (Morgan et al., 1988). Bu anlayış modern biyomedikal yaklaşımlar için de temel teşkil etmiştir. Dünya Sağlık Örgütü'nün (DSÖ) 1948'de tanımladığı sağlık, "sadece

hastalık ve sakatlığın olmayışı değil, bedensel, ruhsal ve sosyal iyilik hali" olarak tanımlanmış, ancak bu tanım çeşitli eleştiriler almıştır (Leonardi, 2018; Habersack & Luschin, 2013). Schramme (2023), DSÖ'nün sağlık tanımının mükemmel sağlığı ifade eden ulaşılması zor bir ideal yorumlanabileceğini belirtmiştir. Biyomedikal model hastalıkları ilaç veya cerrahi müdahalelerle tedaviye odaklanırken (Weatherall, 1996), holistik model ise beden, zihin ve ruhu bir bütün olarak ele alır (American Holistic Health Association, 2023). Holistik yaklaşım, sağlığı tüm sistemlerin dengesi olarak görür ve iyileşmeyi bedenin doğal potansiyelinden beslenerek sağlar (Badash et al., 2017). Bu çalışma, biyomedikal modelin eksikliklerini görerek, bütüncül bir yaklaşım olan Biyopsikososyal (BPS) modeli teorik çerçeve olarak ele almaktadır.

Baranov (2008) biyotıbbı üç ontolojik perspektiften incelemektedir. İlk perspektif, biyotıbı modern tıbbın ana çerçevesi olarak görür; bu bakış açısı hastalığı bedensel bir fenomen olarak tanımlar ve hastayı pasif bir alıcı olarak kabul eder. İkinci perspektif, biyotıbı sembolik-kültürel bir uygulama olarak değerlendirir ve bilimsel görünümün arkasındaki ideolojik gücü vurgular. Üçüncü perspektif ise biyotıbı toplumsal kontrol aracı olarak eleştirir ve sınıf ayrımları güçlendirdiğini belirtir (Hughes, 2015).

Biyotıp modeli, eleştirilen 'reductionism' ve 'medico-centrism' gibi sınırlılıkları dile getirilmiştir; sağlık anlayışını biyolojik faktörlere indirgerken sosyal, kültürel ve psikolojik etmenleri göz ardı eder (Markovic ve diğerleri, 2008; Johansson ve diğerleri, 1999). Baszanger (1998), hekimlerin hücresel patolojiyi önceliklendirdiğini, psikososyal durumları ise genellikle daha az önemli gördüklerini belirtmiştir. Bu, tarihsel bir önyargıyı yansıtır. Biyotıp yaklaşımı, akıl ve bedeni ayıran Cartesian düşünceye dayanmaktadır; bu ayrım, hastalığı bedende bağımsız bir varlık olarak ele alır (Comaroff, 1982). Foucault (1973) ise tıbbın gözlem gücünü vurgular ve insan bedeninin bilim nesnesi olarak nasıl constitüle edildiğini açıklar. Bu bağlamda, 'medikal bakış' ve 'bedenin nesneleşmesi' kavramları ön plana çıkar.
Sonuç olarak, biyotıp perspektifinin temel felsefesi, insan bedeninin gözlem ve izleme yoluyla incelenmesine dayanmaktadır. Bu kavramlar, bölüm 4.1 ve 4.2'de katılımcıların anlatımları ile operasyonel hale getirilecektir.

Beden, Sosyal Dünya, Acı ve İnsan Deneyimi

Hastalığı anlamak, onu yaşanmış bir deneyim olarak ele almayı gerektirir; bu durum Merleau-Ponty (1962) tarafından vurgulanmaktadır. Bu bakış açısı, hastalığın bireyin öz benliğini ve dünya ile etkileşimini etkilediğini kabul eder ve nesnel gözlemlerin ötesine geçer. Biyomedikal uygulamalar genellikle hastaların deneyimlerini göz ardı etmiş olsa da, fenomenolojik ve sosyal inşacı yaklaşımlar bedenin sosyal boyutlarını içermeye başlamıştır (Mauss, 1973; Merleau-Ponty, 1962; Bourdieu, 1977). Beden, sosyal dinamiklerle iç içe geçmiş olarak görülmekte ve sosyal süreçlerin bedensel deneyimleri nasıl şekillendirdiği vurgulanmaktadır (Guttmacher, 1979; Kleinman, 1988; Scheper-Hughes & Lock, 1991).

Feminist eleştiri, Kartezyen ikili anlayıştan kaynaklanan bedenin mekanik ele alınışına karşı çıkarak bedeni hisseden ve aktif bir varlık olarak görmektedir (Leder, 1984). 1970'lerden bu yana feminist akademisyenler, kadınların bedenselliğinin sosyal ve kültürel yönlerini inceleyerek bu boyutları göz ardı eden biyomedikal modelleri sorgulamaktadır (Bordo, 1993; Chrisler, 2004; Sullivan, 2001). Literatür, feminist tartışmalarda biyolojik belirlenimcilik ve sosyal inşacılık arasında bir gerilim olduğunu ortaya koymaktadır (Lupton, 2012). Bir bakış açısı, kadınların bedensel deneyimlerini güçlendirici olarak değerlendirirken, diğer bir görüş bu durumu, kadınların dışlanmasına ve baskılanmasına katkıda bulunduğu gerekçesiyle eleştirmektedir (Lupton, 2012). Bu tartışma, sosyal bilimlerin belirlenimcilik ve bedenin sosyal analiz için önemine dair daha geniş bir tereddütü yansıtmaktadır (Turner, 1996). Beden, sosyal etkileşimleri ve algıları şekillendirmede hayati bir rol oynamaktadır.

Grosz (1994), bedenin maddeselliğinin cinsiyet ve cinsellik anlayışında önemli olduğunu vurgulamakta, sosyal inşaların bedensel deneyimlerden ayrılamayacağını belirtmektedir. Ancak, Fausto-Sterling (2000) ve Fine (2012) gibi eleştirmenler, Grosz'un yaklaşımının belirlenimcilik risklerini barındırdığına dikkat çekmektedir. Sullivan (2015), cinsiyetin ve biyolojinin dinamik bir kavram olarak anlaşılması gerektiğini savunarak, sağlıkta biyolojik ve sosyal faktörlerin etkileşimini ön plana çıkarmaktadır.

Sullivan, biyoloji-kültür ikiliğini eleştirerek sosyal ortamlarla biyolojik süreçlerin entegre edilmesini savunur. Bu bakış açısı, sağlık anlayışını geliştirmekte ve sosyal eşitsizliklerin fizyolojik özellikler üzerinde nasıl tezahür ettiğini açıklamaktadır (Sullivan, 2015). 'Yeni maddesellik' de feminist teoride maddeselliğin göz ardı edilmesini sorgulayarak, maddeyi aktif ve dinamik bir varlık olarak kabul eder (Barad, 2003; Bennett, 2010). Bu yaklaşım, cinsiyet ve sağlık anlayışında madde ile yaşamın karmaşıklığını anlamak için yeni perspektifler sunmaktadır.

Yeni materyalist feministler, diskur ile maddi olanın, doğal ile kültürel olanın, beden ile sosyal inşanın karşılıklı ilişkisini daha nitelikli bir şekilde ele almayı amaçlamaktadır (Jagger, 2015). Barad (2007), agential realist ontolojisiyle, gözlemci ile gözlemlenen arasındaki ayrımı reddederek, insan ve insan-dışı varlıkların etkileşimli ilişkilerini vurgular (Benavente, 2010). Sullivan (2015), insan ilişkilerinin karmaşıklığını anlamak için bu etkileşimleri dikkate almayı önerir. Dolezal (2015), bedenlerin kültürden izole olmadığını, dinamik ve değişken yapılar olduğunu belirtir. Feminist yazarlar, bedenin etik, sosyal ve politik tartışmalardaki önemini vurgulamış ve embodiment felsefesi üzerindeki etkilerini artırmıştır. Bu bağlamda, Sullivan (2015), Barad (2007), Bordo (1993), Bobel (2010) ve Grosz (1994) gibi yazarların eserleri, kadınların bedensel deneyimlerini açıklamak için tartışma alanları sunmaktadır.

Diğer yandan, yapısalcı bir perspektiften bakıldığında, kadın beden deneyimlerinin sosyal inşalar olduğunu ve tarihsel patriyarkal tanımların bu deneyimleri kullanarak kadınları kamusal ve ekonomik alanlardan dışladığını savunur (Lupton, 2012). Bu bakış açısı, cinsiyetler arası eşitsizlikleri azaltmayı amaçlar. Hekman (2008), diskurun maddi olanın önüne geçtiğini ve bu durumun nesnel gerçeklik anlayışımızı etkilediğini belirtir. Sonuç olarak, bu bölümde, kadın bedeninin özgünlüklerini vurgulayan feminist görüşler ile kadın bedeninin tamamen sosyal inşalar olduğu yönündeki relativist bakış açıları ele alınmıştır. Bu tezde, bedenin sosyal ve kültürel koşullarla birlikte değerlendirilmesi gerektiği önerilmektedir. Beden, yalnızca bir kültür nesnesi değil, aynı zamanda sosyal bir varlıktır; ve aynı zamanda biyolojik bir mekanizma olmanın ötesinde, toplumsal bir yapıdır.

Holistik Sağlık ve Hastalık Yaklaşımı

Gabor Maté'ye (2019) göre, 'iyileşme' kelimesi, 'bütün' anlamına gelen antik bir kökenden gelmektedir; bu nedenle iyileşmek, bütünleşmektir. Antik Yunan'da 'Holos' kavramı, hastalıkların yalnızca etkilenen kısmı değil, tüm kişiyi etkilediğini öne sürmüştür (Drossman, 1998). Holistik görüş, bireyi parçaların bir koleksiyonu olarak değil, entegre bir bütün olarak ele alır ve bu görüş birçok geleneksel tıp sisteminde merkezi bir yer tutar. Örneğin, geleneksel Çin tıbbı 'qi' (hayat enerjisi) dengesini sağlık için kritik görürken, Ayurvedik tıp, üç 'dosha'nın (vata, pitta ve kapha) dengelenmesine odaklanır.

Modern dönemde, biyotıp yaklaşımının sınırlılıkları görülmekte ve holistik uygulamalara ilgi artmaktadır. Batı tıbbı belirli hastalıkları tedavi etme konusunda önemli ilerlemeler kaydetmiş olsa da, genellikle tüm bireyi ele almanın önemini göz ardı etmiştir. Hastalık nadiren tek bir faktörden kaynaklanır; çoğunlukla beden, psikoloji ve çevre etkileşim halindedir (Berg & Sarvimäki, 2003). Holistik sağlık yaklaşımı, fiziksel, psikolojik ve sosyal faktörlerin birbirine bağlılığını kabul eder. Holistik yaklaşım, bir bireyin fiziksel, duygusal, zihinsel ve ruhsal boyutlarının tümünü kapsar ve bu boyutların dengesizliğinin genel sağlığı etkileyebileceğini savunur (Guttmacher, 1979).

Holistik yaklaşımın merkezinde, bireyin daha büyük bir yaşam ağı içinde yer aldığı inancı yatar. Bu perspektif, kendisiyle, diğerleriyle ve doğal dünya ile ilişki kurmanın önemini vurgular. Bu bölümün devamında, kadınların üreme sağlığının analizi için holistik perspektifin bir örneğini yansıtan BPS teorik yaklaşımını sunacağım.

Biyopsiko-sosyal Model: George Engel'in BPS Sistem Teorisi

Sokrates'in "Bedende zihin dışında hastalık yoktur" sözü, zihin-beden bağlantısını vurgular; fiziksel sağlığın zihinsel ve duygusal durumlarla etkilendiğini gösterir. Biyopsiko-sosyal (BPS) model, 1977 yılında tıp doktoru ve psikiyatrist George Engel tarafından bilimsel olarak tanıtılmıştır. Engel, hastaların bütün olarak ele alınması gerektiğini savunmuş ve bu modeli indirgemeci biyomedikal modele alternatif olarak sunmuştur (Engel, 1981; Engel, 1977).

Engel'in “Yeni Bir Tıp Modeline İhtiyaç” başlıklı makalesi, tıbbi durumu anlamanın sadece biyolojik bir perspektifin ötesine geçtiğini belirtir (Engel, 1977). BPS modeli, fiziksel, psikolojik ve sosyal faktörlerin etkileşimini kabul ederek sağlığa bakışın kapsamlı olmasını sağlar (Trachsel et al., 2023; Lugg, 2022). Guillemin et al. (2015) bu yaklaşımın, geleneksel biyomedikal modelin eksikliklerini giderme çabası olduğunu vurgular. Biyomedikal model, hastalıkları sadece fiziksel faktörlere atfederken, BPS modeli psikolojik ve sosyokültürel faktörlerin de önemli etkilerini tanır (Flor & Turk, 2011). Bu model, bireylerin sağlık ve hastalığını şekillendiren karmaşık etkileşimleri göz önünde bulundurarak daha holistik bir anlayış sunar (Smith, 2021).

BPS modelinin eleştirileri arasında bilimsel olarak test edilememesi ve klinik uygulamada zorluklar bulunmaktadır (Card, 2023). Smith et al. (2013), bu eleştirilerin yeterli araştırma yapılmamsından kaynaklandığını savunur. Modelin empirik, tekrarlanabilir ve test edilebilir hale gelmesi için hasta merkezli görüşme yönteminin gerekli olduğu ifade edilmiştir (Smith, 2021).

Sonuç olarak, BPS modeli, geleneksel biyomedikal perspektiften daha kapsamlı bir yaklaşım sunarak sağlık ve hastalık üzerindeki karmaşık faktörleri anlamamıza yardımcı olur.

Biyopsiko-Sosyal (BPS) Modelinin Türkiye Bağlamındaki Uygulamaları ve Boşlukları

Son yıllarda Türkiye'de BPS modeline olan ilgi artmıştır. Koloğlu ve arkadaşları (2009) ile Şen (2013), BPS modelinin depresyon tanısı ve aile hekimliğindeki klinik uygulamalarına odaklanmıştır. Uncu ve Akman (2004) ile Akman ve Ünalan (2010), modelin teorik temellerini incelemiş ve birinci basamak hekimleri için eğitim kaynakları sağlamıştır. Cantekin ve Esen (2023), modelin çocuk koruma sistemlerindeki uygulanabilirliğini tartışmıştır. Ayrıca, Aktürk ve Görgün (2012) ile Demir (2020), BPS çerçevesindeki hasta merkezli, birey odaklı ve aile odaklı bakım arasındaki farklılıkları ele almıştır. Sezer Korucu ve arkadaşları (2021), BPS modeline gelişimsel bir bakış açısı sunarken, Fidancıoğlu ve arkadaşları (2021) pandemide onkolojik rehabilitasyonda BPS modelinin entegrasyonuna odaklanmıştır.

Ancak, kadınların üreme sağlığına dair BPS çerçevesinde önemli bir araştırma eksikliği bulunmaktadır.

Aile Hekimliği (AH) modeli, Türkiye'de 2003'te Sağlık Dönüşüm Programı ile hayata geçirilmiştir (Öcek et al., 2014). Avrupa'daki sağlık reformlarından etkilenen Türkiye'de AH, hasta merkezli ve bütüncül bir yaklaşım benimsemiştir. Ancak, mevcut uygulamalar teorik idealden uzak kalmaktadır. Öcek ve arkadaşlarının (2014) bulgularına göre, aile hekimleri başlangıç noktası olarak sınırlı bir rol oynamaktadır. BPS modelinin temel bileşenleri teorik olarak AH'ye entegre edilse de, pratikte yetersiz kalmaktadır (Saygılı & Ungan, 2023). Bu durum, teorik modeller ile uygulama arasındaki önemli bir boşluğu ortaya koymaktadır.

TCAM'a Yönelimin Analizi

Yapılan görüşmelerde, kadınların adet sancısı ve üreme sağlığı sorunlarının yalnızca fiziksel ve psikolojik faktörlerle değil, sosyal ve kültürel bağlamda daha iyi anlaşılabileceği ortaya çıkmıştır. Kadınların sağlıklı olmaya, menstrüasyona ve bedenlerine atfettikleri anlam, kültürel beklentiler ve ilişkisel konular (özellikle bedenleri, eşleri ve arkadaşlarıyla olan ilişkileri) önemli rol oynamaktadır.

Bu bölümde, Türkiye'de TCAM ve alternatif tedavi uygulamalarını tercih eden, eğitimli ve orta sınıf kadınların deneyimlerini inceleyeceğim. Öncelikle sağlık durumlarını detaylandıracak, ardından üreme organlarıyla ilgili ağrı ve çözülmemiş sağlık sorunları hakkındaki hikâyelerine ve tıbbi doktorlarla, jinekologlarla yaşadıkları deneyimlere yer vereceğim.

Katılımcılar, alternatif uygulamalara yönelirken, sağlık ve hastalığın biyolojik, psikolojik ve sosyal yönlerinin bütünselliğini vurgulamaktadır. Biyomedikal modelin sınırlamaları, kadınların deneyimlerinde açıkça görülmektedir; burada tıbbi bakış açısı bedeni yalnızca belirtilere indirgemekte ve acısının öznel doğasını göz ardı etmektedir. Rahatsızlığını ifade etmesine rağmen, doktorun polikistik over sendromu (PCOS) ile ilgili standart bir yaklaşım benimsemesi, Nüzhet'in kendisiyle olan bağlantısını kaybetmesine ve hayal kırıklığına uğramasına neden olmuştur. Bu deneyim, onu bedenine yeni bir şekilde yaklaşmaya ve acısını anormal olarak algılamaya yönlendirmiştir.

Nüzhet'in bu farkındalığı, Rapp (1992) ve Chrisler (2004) gibi feminist sağlık bakış açılarıyla örtüşmektedir; bu bakış açıları kadın sağlığına bütünsel bir yaklaşımın önemini vurgulamaktadır. Dr. Christiane Northrup'ın (2010) kadınların bedenleriyle yeniden bağlantı kurmaları konusundaki savunusundan etkilenen Nüzhet, geleneksel tıbbın onu hayal kırıklığına uğratması sonucunda alternatif yöntemler arayışına girmiştir. Bu durum, genellikle hastaları nesneleştiren ve bireysel deneyimlerini göz ardı eden tıbbi uygulamalara yönelik daha geniş bir eleştiriyi yansıtmaktadır. Bu süreçte, Nüzhet belirtilerini beslenmesiyle ilişkilendirmiştir; bu da sağlığına dair anlayışında bir kayma yaşandığını göstermektedir. Bu değişim, Devroede'nin (2000) 'kloakal düşünme' kavramıyla örtüşmektedir; bu kavram beden sistemlerinin birbirleriyle olan bağlantısını vurgular. Bu bütünsel bakış açısı, geleneksel tıbbın parçalı yaklaşımını sorgulayarak, hem fiziksel hem de duygusal boyutları dikkate alan daha entegre bir sağlık anlayışını savunmaktadır.

Bedensel Şifa ve Kadın Çemberleri: Yeni İlişki Biçimlerini Geliştirmek

Mayıs 2021'de pandemi sonrası ilk kez şehir dışına seyahat etmek üzere hazırlık yapıyordum. Altı aydır çevrimiçi katıldığım Gizemli Dişilik Eğitmenlik Eğitimi'nin son kısmı, kadın çemberleri düzenleyerek gerçekleştirilecekti. Bu çemberi yönetmek için kendimi hem zihinsel hem de fiziksel olarak hazırlamıştım, ancak içimde bir ağırlık hissediyordum. Aylarca yaptığım beden egzersizleri, yoga ve diğer uygulamalar, derin duygular uyandırmıştı. Şerianna Boyle'un Emotional Detox (2019) kitabında belirttiği gibi, bedensel detoks sürecinde duygusal toksinler de serbest kalıyor; bu da kaygı ve korku gibi bastırılmış duyguları ortaya çıkarıyordu.

Gabor Maté, bedensel sağlığın duygusal iyilik haliyle derin bir bağlantısı olduğunu vurguluyor. When the Body Says No (2019) kitabında, duygusal bastırmanın fiziksel semptomlara dönüşebileceğini açıklıyor. Bu bağlamda, detoks süreçlerinde yaşanan duygusal serbest bırakmaların iyileşme için kritik olduğunu savunuyorum. Alice Miller'in The Body Never Lies (2006) eseri, çocukluk travmalarının ilerideki yaşamda nasıl tezahür ettiğini inceliyor. Bu yaklaşımlar, kadınların üreme sağlığının biyopsikososyal bir çerçevede değerlendirilmesi gerektiğini gösteriyor.

Gönül'ün deneyimleri, nefes tekniklerinin duygusal patlamalara yol açabileceğini ve geçmiş travmaların işlenmesine yardımcı olduğunu gösteriyor. Nefes çalışmaları

sırasında yaşanan "ağlama nöbetleri" ve "öfke", bastırılan duyguların ortaya çıkmasına imkan tanıyor. Bu süreç, affetme çalışmalarıyla birleştiğinde, duygusal iyileşme için önemli bir adım haline geliyor.

Bedenselliğin Şifada Rolü

Christiane Northrup (2013), Kadınların Bedeni, Kadınların Bilgeliği adlı kitabında, kadın organlarının—özellikle yumurtalıklar, rahim ve göğüslerin—duygular ve anılar, hatta annelerimizden ve ninelerimizden gelenlerin depolandığı yerler olduğunu açıklar. Şifa, bu bilgelikle bağlantı kurmaktan gelir. Doğu tıbbında, bedensel ve zihinsel deneyimlerin ayrı olmadığı kabul edilir. Duygusal deneyimler, beden dokularını ve organ sistemlerinin işlevini etkiler; bu nedenle, duygular bedende herhangi bir yere hapsolmuş olarak kabul edilemez (Anandi, 2024).

Gizemli Dişilik Eğitiminde, "rahim bilgeliği" veya "rahim şifası" olarak bilinen bedensel, zihinsel ve psikolojik içgörüler sağlayan uygulamalarla da ilgilendim. Bu uygulamalar meditasyonlar, masajlar, dans, yoni spa ve yoni yumurtası kullanımını içeriyordu. Eğitim sürecinde bilimsel araştırmalara devam ederken, bu deneyimler tamamen pratiğe dayalıydı. Pratik ödevler yaparak, örneğin üç günlük beslenme detoksu veya bir saatlik karın ve lenf masajı gibi uygulamaların sonuçlarını gözlemledik. Kadın Bilgelik & Şifa Sanatı Kampı ve Kadın Bilgelik & Şifa Sanatı Sertifika Programı gibi önceki deneyimlerim de benzer uygulamalara dayanmaktaydı.

Gizemli Dişilik Eğitiminde 20 kadın yer aldı ve 2021'de eğitmen olarak sertifikamı aldım. 2022'de başka bir grup için asistanlık yaptım. Eğitim, kadınlara feminen doğalarıyla bağlantı kurma ve yaşamlarındaki ilişkisel ve fiziksel sorunları aşma fırsatı sunuyordu. Ancak katılımcıların çoğu, yumurtalık kistleri, endometriozis, rahim kanseri gibi üreme sağlığı sorunları yaşıyordu. Alan çalışmamda, amenore yaşayan genç bir kadın, erken menopoz tanısı almış bir kadın ve tiroid dengesizliği yaşayan bir kadın benzer yaşam tarzı değişiklikleri benimsemeye teşvik ediliyordu.

Adet Sağlığinin Analizi: Durumlar, Zorluklar ve Yaklaşimlar

Bu tezdeki alan çalışmasından elde edilen kadın alıntıları, adet ile ilgili bazı ortak temaları vurgulamaktadır. Öncelikle, adetle ilgili tabular ve sessizlik dikkat

çekmektedir. Kadınlar, bu konunun ya hiç konuşulmadığını ya da yalnızca kadın akrabalar veya arkadaşlar arasında fısıldanarak tartışıldığını ifade etmektedirler. Açık tartışma eksikliği, özellikle ilk adet deneyiminde kafa karışıklığı, utanç ve korku duygularına yol açmaktadır. İkinci bir konu ise üreme sağlığı hakkında resmi eğitimin eksikliğidir. Annelerden veya yaşlı kadınlardan menstrüasyon hakkında rehberlik sağlanmamaktadır; bu boşluk, arkadaşlar veya nadiren öğretmenler gibi gayri resmi kaynaklardan sınırlı bilgilerle dolmaktadır. Üçüncü tema ise menstrüasyona dair kültürel ve sosyal damgalardır. Menstruasyon, genellikle utanç verici veya kamu tartışması için uygun olmayan bir konu olarak görülmektedir. Babalar ve erkek figürlerin bu konuşmalardan dışlanması, menstruasyonu gizlilik ve rahatsızlık ile ilişkilendiren toplumsal normları pekiştirmektedir. Ancak, Nüzhet'in babasıyla olan olumlu deneyimi, destekleyici bir katılımın nadir bir örneğini sunmaktadır. Tabu, sessizlik, resmi eğitim eksikliği ve menstrüel damgalar yeni konular değildir; bunlar, menstrüasyon üzerine yapılan çalışmalarda uzun süredir ele alınmaktadır. Tezimin alan çalışmasında bu temaların ortaya çıktığını gözlemlemekteyim. Ancak, menstrüasyonla ilişkili hijyen vurgusunu daha derinlemesine analiz etmeyi amaçlıyorum.

Menstrüel Hijyen Üzerine Yeniden Değerlendirme

Bu bölüm, menstrüel hijyen konusundaki baskın odaklanmayı eleştirel bir şekilde incelemekte, yararlarını ve dezavantajlarını yeniden değerlendirerek menstrüel sağlığı anlamada daha bütünsel bir yaklaşım savunmaktadır. Dünya Sağlık Örgütü (DSÖ), 22 Haziran 2022'de İnsan Hakları Konseyi'nin 50. oturumunda menstrüel sağlık ve haklar üzerine açıklamalar yapmıştır. DSÖ, menstrüasyonu bir hijyen meselesi değil, sağlık sorunu olarak tanıma ve yeniden çerçeveleme çağrısında bulunmaktadır. Bu açıklama, menstrüasyonun DSÖ programlarında önceki dönemde bir hijyen meselesi olarak ele alındığını göstermektedir. DSÖ, hijyenik menstrüel ürünlere ve güvenli hijyen tesislerine erişimin önemini vurgulamaktadır (Clark & As Sy, 2020). Dünya Bankası (DB) da menstrüel sağlık açısından hijyen ve sanitasyonu dikkate almaktadır. Menstrüel hijyen ürünlerine erişim, menstrüel sağlığı iyileştirmek için kritik öneme sahiptir (Dünya Bankası Grubu, 2021). DB, menstrüel ürünlerin eğitim materyalleri ile birlikte tanıtılması gerektiğini savunmaktadır. Ayrıca, Menstrüel Hijyen Günü (MH Day), 2013 yılında Alman sivil toplum

kuruluşu WASH United tarafından başlatılmıştır ve Türkiye'de de tanınmaktadır. Birleşmiş Milletler Nüfus Fonu (UNFPA), kadınların güvenli sanitasyon tesislerine erişimini sağlamakta ve 'onur paketleri' dağıtmaktadır. Tüm bu küresel girişimlerin ana odağı, hijyenik menstrüel ürünlere erişim sağlamaktır. UNFPA, menstrüel sağlık farkındalığını artırmak için eğitim sunmakta, damgalar ve mitler üzerine çalışmaktadır (Menstrual Health 2024).

Kadınlara sağlanan bilgilerin amacı, bilgi üretimindeki egemenliği ve bunun sonucunda ortaya çıkan "epistemik adaletsizlik" konusundaki tartışmalarla ilişkilidir. Epistemik adaletsizlik, bilgi üreten sistem ve yapıların çeşitli marjinalleşmelere yol açtığı durumları ifade eder. Fricker (2007) ve Tuana (2019) çalışmalarından hareketle, Hutton ve Cappellini (2022), epistemik adaletsizliğin; dışlanma, susturma, görünmezlik, işitilmezlik ve katkıların çarpıtılması gibi durumları içerdiğini belirtmektedir. Bu bağlamda, dışlanma, belirli bakış açıların tartışmalardan aktif olarak çıkarılması anlamına gelirken, susturma, bireylerin görüşlerini ifade etmesine engel olunması durumunu ifade eder. Görünmezlik, belirli ön yargılar nedeniyle bazı bilgilerin veya deneyimlerin göz ardı edilmesidir. İşitilmezlik, bir kişinin konuşma fırsatı olsa bile sesinin duyulmadığı durumları tanımlar.

WHO'nun menstrüasyonla ilgili açıklamasında, utanç duygularını ele almak ve kadınların menstrüasyon sırasında sosyal ve profesyonel etkinliklere katılımını sağlamak ön plana çıkmaktadır. Ancak, bu katılımın neden önemli olduğu ve mevcut bilgilerde yeterince ele alınmayan diğer ihtiyaçların olup olmadığını eleştirel bir şekilde incelemek gerekmektedir. WHO'nun “Kadın Sağlığı” başlığı altındaki açıklaması, kadın sağlığının sosyokültürel faktörlerden kaynaklanan ayrımcılık nedeniyle özel bir endişe olduğunu vurgulamaktadır. Ancak bu, kadın sağlığının neden önemli olduğunu yeterince açıklamamaktadır.

Kritik bir değerlendirme olarak, iki ana konu üzerinde durmak istiyorum: Birincisi, küresel girişimlerin kadın meselelerine yönelik yaklaşımlarının post-gelişme feminist perspektiften değerlendirilmesi; ikincisi, menstrüasyon sorunlarının hijyen üzerinden ele alınması. Feminist post-gelişme yaklaşımından bakıldığında, uluslararası kuruluşların dezavantajlı kadınları temsil etme biçimi eleştirilmektedir. Feminist

post-gelişme araştırmaları, marjinal kadınların gelişim çabaları içindeki temsilini sorgulamaktadır (örneğin: Chandra Mohanty, 1984; Moghadam, 2003). Alhelou ve diğerleri (2022), küresel politikaların analizinde, kızların menstrüel ihtiyaçlarını göz ardı eden politikaların varlığını göstermektedir. Kadınların böyle anlatılarda nesneleştirilmesi, "kız güçlendirme" kavramının gelişim çabalarında nasıl sürdüğünü ortaya koymaktadır. Özden'in (2010) Türkiye'deki Üreme Sağlığı Programı üzerine yaptığı tez çalışması, kadınların bedenlerinin erkek odaklı tıp pratiğine tabi tutulduğunu göstermektedir.

Bobel'in çalışması, küresel organizasyonların menstrüel hijyen konusundaki yaklaşımlarını kapsamlı bir şekilde incelemektedir. Bobel'in "The Managed Body" adlı kitabı, menstrüel hijyen yönetiminin, küresel güneydeki menstruasyon gören kızları destekleyen bir sosyal hareket olduğunu ortaya koymaktadır. İlk bakışta, kitabın başlığı, feminist araştırmacılar tarafından eleştirilen "gelişim söylemi" ile kızların menstrüel alışkanlıklarının yönetim meselesi olarak ele alınması arasında bir bağlantı sunmaktadır.

Sonuç

Bu tez, yüksek eğitimli, profesyonel, orta sınıf ve kentsel kadınların, üreme sağlığı koşulları için biyomedikal tedavi yöntemlerine ek olarak veya bunların yerine Nötr, Tamamlayıcı ve Alternatif Tıp (TCAM) yöntemlerini tercih etme nedenlerini araştırmayı amaçlamıştır. TCAM ve alternatif iyileşme uygulamalarını kullanmış kadınlarla yapılan derinlemesine görüşmeler, yerel bakış açısının dönüştürücü gücünü ortaya koymuştur. Bulgular, ortodoks profesyonel (uzman) bilginin baskınlığını sorgulamakta ve kadınların deneyimlerinin, özellikle menstruasyonla ilgili koşullar açısından üreme sağlığını yeniden tanımlama yollarını vurgulamaktadır. Bu çalışmadaki kadınlar yalnızca biyomedikal otoriteyi sorgulamakla kalmamış, aynı zamanda biyomedikal uzmanlar tarafından tedavi edilemez olarak görülen üreme sağlığı sorunlarını yönetmede başarı elde etmişlerdir. Bu durum, üreme sağlığındaki uzman bilgimizi yeniden değerlendirme ve genişletme ihtiyacını vurgulamakta, yerel bilginin sağlık sonuçlarını şekillendirmedeki önemini kabul etmektedir. Bu kadınların yaşanmış deneyimlerini ve içgörülerini entegre

ederek, sağlık hizmetleri daha etkili, kapsayıcı ve kadınların karşılaştığı gerçek zorluklara daha duyarlı hale gelebilir.

Bu çalışma, teorik bir perspektiften biyolojik belirlenimciliği eleştirmekte ve sağlık ile hastalık anlayışında bedenlenmiş deneyimlerin değerini vurgulamaktadır. Menstrüasyon, geleneksel olarak biyolojik bir sorun olarak çerçevelenmişken, modern çalışmalarda kültürel ve sosyal yapıların öne çıktığı görülmektedir. Ancak bu tez, menstrüasyonun ve dolayısıyla kadınların üreme sağlığının, biyolojik, psikolojik, sosyal ve kültürel boyutlarını kabul eden bir çerçevede anlaşılması gerektiğini savunmaktadır. George Engel'in Biyopsikososyal (BPS) modeli, kadınların üreme sağlığı koşullarının tedavi süreçlerini analiz etmek için kapsamlı bir bakış açısı sunmuştur. TCAM yöntemlerinin potansiyel faydalarına rağmen, araştırma BPS modeline dayalı sistematik tedavi protokollerinde bir boşluk olduğunu da ortaya koymuştur. Kadınlar genellikle sağlık sorunlarını deneme yanılma yoluyla çözmeye bırakılmakta, onları yönlendiren bir yapılandırılmış yaklaşım bulunmamaktadır. Bu durum, kadınların hatalara veya zararlara açık hale gelmelerine neden olmaktadır. Bununla başa çıkmak için, BPS modelini içeren ve kadınların üreme sağlığı sorunları için bütünsel, hasta merkezli bakım sunan tedavi protokollerinin geliştirilmesi gerekliliği açıktır.

Ayrıca, aile dinamikleri, geçmiş travmalar, toplumsal baskılar ve ilişki zorlukları gibi temalar, görüşmeler boyunca ortaya çıkmıştır. Bu konular—ilişkilerle ilgili korkular, romantik veya cinsel etkileşimlerdeki zorluklar ve evlilik ile annelikle ilgili toplumsal beklentiler—görüşülen kadınların iyileşme yolculuklarında merkezi bir rol oynamıştır. Bu bulgular, üreme sağlığına yönelik yaklaşımların yalnızca fiziksel semptomları değil, aynı zamanda psikolojik ve duygusal boyutları da ele alması gerektiğini daha da vurgulamaktadır. Gabor Maté ve Alice Miller tarafından vurgulanan detoksifikasyon sırasında yaşanan duygusal boşalma, duygusal ve fiziksel sağlık arasındaki derin bağlantıyı ortaya koymaktadır. Maté'nin (2019) toksik stres kavramı ve Miller'ın (2006) çocukluk travmalarını incelemesi, çözülmemiş duyguların hastalık olarak nasıl tezahür edebileceğini ve bu duyguların serbest bırakılmasının iyileşme sürecinin ayrılmaz bir parçası olduğunu göstermektedir. Bu içgörüler, zihin, beden ve duyguların birbirine bağlılığını

vurgulayan biyopsikososyal çerçeveyle uyumludur. Bu nedenle, detoks veya nefes çalışması gibi uygulamalar sırasında duygusal boşalma, yalnızca tesadüfi değil, aynı zamanda genel iyileşme sürecinin temel bir parçasıdır; çünkü bu, bedenin ve zihnin çözülmemiş travmaları işlemesine ve bütünsel bir iyilik haline doğru ilerlemesine olanak tanır. Northrup'un bedeni duygular ve anılar için bir depo olarak görmesi, iyileşmeyi yalnızca fiziksel tedavi olarak değil, duygusal ve psikosomatik faktörlerle derinlemesine iç içe geçmiş bir süreç olarak anlamak için bir zemin oluşturmaktadır; bu, Engel'in BPS tıbbi modeli (1977) tarafından kavramsallaştırılmıştır.

Geleneksel Çin Tıbbı ve Ayurveda gibi Doğu geleneklerinden yararlanarak, beden ve zihin birbirinden ayrılmaz olarak görülmekte, duygusal deneyimlerin fiziksel sağlığı doğrudan etkilediği kabul edilmektedir. Rahim iyileşmesi, yoni yumurtaları ve yoni spa uygulamaları gibi uygulamalar, kadınların bedenleriyle ve onların bilgeliğiyle yeniden bağlantı kurmasının duygusal ve fiziksel iyileşme sağlayacağı inancına dayanmaktadır. Meditasyonlar, masajlar ve detokslar gibi bu uygulamaların deneyimsel doğası, bireylerin bedenlerine uyum sağlamalarına ve sağlık yolculuklarının duygusal yönlerini keşfetmelerine yardımcı olmaktadır. Ayrıca, feminist akademisyenler Sullivan ve Grosz, bedenlenmeyi kadın sağlığını anlamada anahtar bir kavram olarak vurgulamaktadır. Bu, bedeni yalnızca biyolojik bir varlık değil, aynı zamanda sosyal, kültürel ve kişisel deneyimlerle şekillenen bir alan olarak tanımayı içermektedir. Beden farkındalığını teşvik eden uygulamalarla etkileşime geçerek, kadınlar sağlıklarının hem duygusal hem de fiziksel boyutlarını ele alabilir, bu da genellikle bu faktörleri göz ardı eden biyomedikal yaklaşımların sınırlamalarının ötesine geçmeyi sağlar. Alan çalışmam, bu alternatif iyileşme uygulamalarının, zihin, beden ve toplum arasındaki karmaşık etkileşimleri tanıyan bir biyopsikososyal sağlık modeli ile nasıl bağlantılı olduğunu vurgulamaktadır. Karın masajı, yoni masajı ve kuru fırçalama gibi uygulamalar yalnızca fiziksel iyileşmeyi değil, aynı zamanda duygusal boşalma ve daha derin bir öz bağlantıyı teşvik etmeyi amaçlamaktadır. Bu bakış açısıyla, iyileşme entegre bir süreç haline gelir ve kadınların bedensel deneyimlerini yeniden kazanmalarını sağlamakta ve güçlendirmektedir. Şekil 5, BPS modelinde kadınların üreme sağlığı için bir grafik sunmaktadır. Grafik, Engel'in BPS modeline ilişkin teorik perspektiflerden ve alan çalışmamdan elde edilen verilerin sentezine dayanmaktadır.

Ayrıca, bu tez, kadın bedeninin döngüsel doğasının incelenmesinin kadınların üreme sağlığı ve iyilik halleri üzerine önemli bilgiler sunduğunu savunmaktadır. Menstrüel döngüyü, her birinin kendine özgü fiziksel, duygusal ve sosyal boyutları olan birbirine bağlı aşamalar dizisi olarak tanıyarak, kadınlar bedenlenmiş deneyimlerine daha derin bir farkındalık geliştirebilirler. Bu farkındalık, yalnızca öz bakım uygulamalarını kolaylaştırmakla kalmaz, aynı zamanda BPS modeli ile uyumlu olan bütünsel bir sağlık anlayışını teşvik eder. Döngü Farkındalığı ve İçsel Mevsimler çerçevesi gibi kavramların entegrasyonu, kadınların doğal ritimlerini onurlandırmaları ve yaşam tarzlarını buna göre uyarlamaları gerektiğini vurgulamaktadır. Sürekli üretkenlik talep eden toplumsal baskılarla başa çıkarken, kadınların döngüsel doğalarıyla uyumlu olmaları iyileşmenin temel bir eylemi haline gelmektedir. Farklı iyileşme uygulamalarında kadınlar tarafından paylaşılan kişisel anlatılar, bedenlerinin ihtiyaçlarını tanımanın ve saygı duymanın dönüştürücü etkisini ortaya koymaktadır. Bu farkındalık, kadınların fiziksel ve duygusal sağlıklarını artırmalarını, toplumsal beklentilerin etkilerini azaltmalarını ve nihayetinde bedenleriyle daha uyumlu bir ilişki geliştirmelerini sağlamaktadır. Ayrıca, pelvik taban disfonksiyonları gibi sorunların bedenlenmiş bir bakış açısıyla ele alınması, biyolojik, kültürel ve sosyal faktörler arasındaki etkileşimi kabul eder. Bu perspektif, biyomedikal alandaki indirgemeci bakış açılarına meydan okuyarak, kadınların üreme sağlığını yaşanmış deneyimlerin ve toplumsal normların daha geniş bir bağlamında anlamanın önemini vurgular.

Sonuç olarak, alan çalışmamdan alınan katılımcıların alıntıları, fiziksel, sosyal ve duygusal boyutları birleştiren bütünsel bir iyileşme yaklaşımını yansıtarak biyopsikososyal (BPS) modelle uyum göstermektedir. Bu farkındalık değişimi, kadınların bedenlerini onurlandırma ve bakım verme gerekliliğini giderek daha fazla tanıdıklarının bir yansımasıdır; özellikle de üreme sağlıkları ve menstrüel döngüleriyle ilgili olarak. Sağlık sorunlarının kök nedenlerini psiko-spirüel bir lensle araştırarak, bu kadınlar kadınlık deneyimleri ve geçmiş travmalarıyla yüzleşmekte, bedenleriyle daha derin bir bağ kurmaktadırlar.

Türkiye'deki kadınlar çemberleri ve çevrimiçi platformlarda yapılan katılımcı gözlemler, biyopsikososyal (BPS) perspektifle kadınların üreme sağlığı ve iyilik

hallerini ele almadaki toplulukların hayati rolünü vurgulamaktadır. Bu toplantılar yalnızca kişisel deneyimlerin paylaşılmasını kolaylaştırmakla kalmaz, aynı zamanda kadınların kültürel normlara meydan okumalarını ve kimliklerini keşfetmelerini sağlayan destekleyici bir ortam yaratır. Katılımcıların anlamlı diyaloglar kurarak dayanışma ve anlayışı pekiştirmeleri, sağlıklarının duygusal ve sosyal boyutlarının derin bir şekilde vurgulandığını gösterir. Kadınlar, birbirleriyle olan etkileşimlerini tanıyarak güçlenme ve iyileşme bulmakta, biyomedikal modelin göz ardı ettiği bireysel mücadeleleri aşmaktadırlar. Ayrıca, bu çemberlerde rahim iyileşmesi gibi uygulamaların entegrasyonu, bireysel iyilik halinin topluluğun kolektif sağlığıyla doğrudan bağlantılı olduğu inancını pekiştirmektedir. Bu perspektif, biyopsikososyal modelle uyumlu olup, sağlık için bütünsel bir yaklaşımı savunmakta; biyolojik, psikolojik ve sosyal faktörler arasındaki etkileşimi dikkate almaktadır. Bu kutsal alanlardaki paylaşılan deneyimlerin vurgulanması, yalnızca bireysel gelişimi beslemekle kalmaz, aynı zamanda toplumsal dönüşüme katkıda bulunarak kadın sağlığında topluluğun önemini güçlendirir. Nihayetinde, bu çemberler, sosyal desteğin ve kolektif güçlenmenin kadınların iyileşme yolculukları için ne kadar kritik olduğunu gözler önüne sererek, kadınların eşsiz deneyimlerini ve ihtiyaçlarını onurlandıran ve kutlayan ortamların geliştirilmesinin gerekliliğini vurgulamaktadır.

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YAZARIN / AUTHOR

Soyadı / Surname : Özcan
Adı / Name : Tuğba
Bölümü / Department : Sosyoloji / Sociology

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