An Alternative Medical Treatment: Reasons for its Selection and Ways of Evaluating its Efficacy[1]

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An Alternative Medical Treatment: Reasons for its Selection and Ways of Evaluating its Efficacy. Complementary and alternative medicine (CAM; usually defined in opposition to biomedicine or orthodox medicine) is use by part of the population (the percentage differs from country to country) exclusively or, more often, in addition to biomedical procedures. The causes of using alternative medicine may vary - from disappointment in biomedicine to preference of alternative medicine as a part of an alternative worldview philosophy in a broader context (Taves et al. 2018). Building on previous knowledge about the use of CAM, the authors address issues of the perception of CAM practices, ways of evaluating their effectiveness, and the role of creation of narrative about the faced problem as the part of coping with the given situation. The study is based on qualitative data from Slovakia.
Sociológia 2022, Vol. 54 (No. 2: 121-143)
https://doi.org/10.31577/sociologia.2022.54.2.5

Key words: *alternative medicine; CAM; efficacy; illness narrative*

Introduction

For most of the countries in the world at present, the way people look after their health is characterized (to a greater or lesser extent) by medical pluralism. Never before have people had such free and extensive access to information. Thus, never before have they had so many opportunities to compare medical opinions, seek out new forms of treatment and talk about health with other people as they do today. There are also changes in the legislation governing health and medicine. Medical pluralism also means that patients have access to more ways for treating illnesses; they can choose a therapy according to the type of illness they are suffering from. They switch between different body concepts, health, and the treatment process (Johannessen 2006). Attitudes to health and a person's subjective perception of their condition can vary depending on socioeconomic status, age, gender, religious beliefs, and overall living conditions.

The World Health Organization classifies health care practices in several ways (based on data from 2013, see Gale - McHale 2015: 1-11): *traditional*

[1] This study was supported by a VEGA grant no. 2/0102/19, „Collective rituals as a tool of social regulation “.

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medicine refers to the knowledge, skills, and practices based on the experiences of a given culture used in the maintenance of health as well as in the prevention or treatment of physical and mental illness; *complementary and alternative medicine* (CAM) is a "set of health care practices that are not part of that country's own tradition or conventional medicine, and are not fully integrated into the dominant healthcare system," and *biomedicine* (conventional, orthodox medicine) as the system based on biology and experimental medicine.[5] For most of the Euro-American world, biomedicine is the normative system, and any "alternatives" are assessed by comparison. Still, as Ross pointed out, "the extreme dominance of Western medicine during the twentieth century is an atypical historical event" (Ross 2012: 1). At the same time, surveys show the popularity of CAM increasing worldwide (Bishop et al. 2007; Barnes et al. 2008).[6] The causes of this phenomenon, the explanation of which is essential from both an academic and applied perspective, have not been fully clarified and remain the focus of many empirical studies (Harris - Rees 2000). The concepts and practices belonging to alternative medicine are culturally determined: the boundary between biomedicine and alternative medicine can shift depending on the cultural context. In certain cases, alternative therapies may be linked to the biomedical system. Clearly, alternative medicine does not represent a single "package" of ideas and practices. It is a dynamic set whose content may vary depending on the cultural and social context. "Alternative" sometimes means medical procedures that have developed in a different cultural (geographical) context. CAM practices and attitudes are explored within medical anthropology, an anthropological sub-discipline that began to take shape in (Western) Europe and the USA during the 1950s - 1960s (Kleinman 1987; McElroy 1996). In Slovakia, it is still a relatively new discipline, but one that is gradually establishing itself, with a growing number of studies (see, for example, Belák et al. 2018; Botiková – Bužeková 2020; Bužeková 2015; 2019; Jerotijević - Hagovská 2019; Kráľová 2020; Pešťanská 2017; Souček - Hofreiter 2017).

There is now a large number of studies on the use of CAM (Fjær et al. 2020; Kemppainen et al. 2018; Wemrell et al. 2017, etc.), focusing on different aspects: gender bias (Keshet - Simchai 2014), specific medical conditions treated with CAM (Pokladníkova et al. 2021; Mesraoua et al. 2021), biases in reasoning among CAM users (Lindeman 2011), etc. Some of them predominantly map the reasons for the choice of CAM and their use for specific health problems, others do not address the causes, but rather try to

[5] We use terms alternative healing, methods, procedure, or therapy as synonyms in this study.

[6] E.g., data from Belgium, France and Finland from the nineties showed that almost third to half of their citizens used some kind of alternative therapy (Vincent - Furnham 1997: 38).

explain the reasoning principles of CAM users. Our aim was to go 'beyond' the explicit statements of informants and analyse the ways in which they justify CAM use and interpret their effectiveness. Further, we investigated the reasons for the choice of CAM (which we address to a lesser extent in this text) and the broader context of the anchoring of the use of alternative medicine in the informants' life philosophies and the way they view these practices. Our research scope has been quite broad, but in this text, we will focus on a particular aspect. The research question we seek to answer here is how do users of alternative medicine approach these practices and what they expect from them? Against what criteria do they evaluate their effectiveness, and how does their interaction with healers influence their interpretations? What factors play a role in the construction of meanings reflecting their experiences with CAM? What does the combination of methods mean in practical terms? How do participants decide on a method, reject another, how do they "know" that a given method works? What is the role of experts in shaping the narrative of the treatment process? [7]

We hypothesize that CAM users do not accept alternative methods and practices uncritically but re-evaluate their efficacy and attitudes towards them. However, a negative experience may not lead to a rejection of CAM but only of the given method. Our aim was to determine what rationales informants resort to, how they justify their attitudes, or what mechanisms may underlie these rationales. Acceptance of a particular method may result from the urgency of the situation the person finds, but this does not automatically mean that the method used will not be questioned by the person. Relationship and communication with the specialist may equally play a role in the perception of CAM. The approach to CAM reflects, in a broader context, the need for a search for meaning behind the events experienced.

For the purposes of the present work, complementary and alternative procedures[8] mean specific non-biomedical procedures used to deal with problems of a physical or mental nature. This means that, as well as various substances from "folk pharmacology," preparations that are not recognised biomedical treatments, consideration will also be given to multiple methods based on energy healing, rituals, dance, music, etc. Barnes et al. (2008: 2) classify alternative medical procedures and therapies according to five basic types: (1) alternative medical systems, (2) biologically based therapies, (3) manipulative and body-based therapies, (4) mind-body therapies and (5) energy healing therapies. We did not focus on specific practices but on those

[7] Although the research problem may appear broadly defined, the individual questions are closely related and build on each other.

[8] We will also use terms such as CAM treatments, practices, therapies, or methods to refer to them. Sometimes we may use also shorter form “alternative therapies” (or equivalents).

mentioned by informants. However, the practices that we analyse here represent mostly group four and five from the mentioned typology.

Our text builds on existing publications focusing on CAM but highlights some important aspects that have not received more attention. While issues such as gender-bias (which is also encountered in our research) or the reasons for choosing CAM were analysed in some detail, less is known about the content level of CAM ideas and attitudes. Drawing on qualitative methodology, our aim was to analyse the implicit and explicit ways in which alternative practices are legitimised by its users, as well as the role and collaboration with the healer in this process (healers as a separate category, however, are not the focus of this study). Below we define several key concepts and ideas related to complementary and alternative medicine. We will then present our own related ethnographic research and its findings. Ethnographic data is used to document the emic perspective, which is then analysed through the prism of selected concepts.

Alternative medicine – key premises

The pioneering research on medical pluralism was conducted by Leslie (1976), who described the co-existence of biomedicine and traditional medicine in China and India (for further information, see Johannessen 2006: 2). It was then found that a system of parallel or even interconnected medical practices was almost universal. On the other hand, the "conflict" between biomedicine and CAM is significantly older than it may appear (for a review, see Bivinis 2015: 13). According to certain opinions, skepticism about biomedical procedures and practices took off in the 1960s and '70s (especially in the USA) in connection with the civil movements spreading at that time. People were especially concerned about using various pharmaceuticals (e.g., drugs given to pregnant women that had fatal consequences for offspring), and they sought out forms of treatment that they evaluated as being less harmful (Dossey – Swyers 1994).

Skepticism about biomedical methods undeniably goes back further in history. For example, the rejection of vaccination is as old as vaccination itself. The first organized groups rejecting vaccination appeared in Britain in the second half of the 19th century. Historians, however, document antivaccine attitudes as early as the early 19th century, parallel to the launch of smallpox vaccination (Grignolio 2018). As in today, attitudes towards vaccines were not grounded only in medical knowledge but represented a moral and political discourse (Beck 1960).

Parallel overlapping systems of medical practice are almost the rule nowadays. In most countries in Europe and the USA, a certain proportion of

the population uses CAM procedures in the medical process (Ross 2012). Data from individual countries vary, but since the 1990s predominantly indicated a growing trend in CAM use across countries in the 'Western' world (Wemrell et al. 2017; Pokladniková - Selke-Krulichová 2017; Kemppainen et al. 2018; Fjær et al. 2020). According to Pokladniková and Selke-Krulichová, the prevalence of CAM ranges from 0.3 to 86% in developed countries (ibid: 160). Data from Sweden (Wemrell et al. 2017) show that in 2015, 71% of respondents used some kind of CAM. Of these, the most significant proportion (53%) used herbal and natural supplements, 33% used the services of CAM providers, and the remaining 32% used one of the self-help methods (yoga, relaxation exercises, etc.). However, as noted by Kemppainen et al. (2018), research on CAM use varies considerably across European countries, making comparisons difficult. According to the authors, this topic is relatively well mapped in the UK and Germany, but less data is available from Eastern Europe. The authors analyzed data from the European Social Survey, Round 7 (edition 2.0, 2014), suggesting about 10% CAM use in Hungary and about 40% in Germany. Souček and Hofreiter (2021) claim that almost 83% of respondents in their survey had used a CAM practice, of which biologically based treatments were the most represented.

Even though social sciences have been dealing with CAM for a long time, there are still some unanswered questions. We know quite a lot about the association between CAM and variables such as gender, age, education, or preferred CAM practices. However, we know considerably less about the interconnectedness of attitudes towards CAM (because it is not a single and consistent system of ideas, there is no CAM "doctrine"); about the sources of these ideas, the relevance that CAM users attach to these sources, etc. Attitudes towards CAM cannot be explained by social factors alone. While these play an essential role in disseminating information about this treatment and its availability, they do not explain how people combine different attitudes, nor how and why they choose to adopt specific alternative therapies. As anthropologists stress, the relationship between attitudes and behaviors is complex. Pro-CAM attitudes and CAM use can be related in different ways (Bryden et al. 2018). Persons who use CAM typically also use biomedical practices (despite the fact that they may be critical of them), may be critical of some CAM practices but use others, etc. Our research addresses these questions.

Background factors affecting the choice for CAM use may include social and economic factors, religion, or specific philosophies of life. In some cases, the cause is (direct or indirect) personal experience of treatment outside official channels (Bivinis 2015: 13). Research conducted in the USA in 2007 (Barnes et al. 2008) showed that several CAM users saw it as a supplement to

biomedicine, not as an alternative or substitute. Souček and Hofreiter (2017) reported similar findings for Slovakia, also Wermell et al. (2017) for Sweden. One possible reason for seeking forms of treatment outside the scope of biomedicine may be that people may be in the dark in questions of health/illness. They do not have enough information, cannot tell whether the doctor treating them is a real specialist, and have prescribed the proper treatment. Sometimes, it is enough that people feel as if a doctor is not paying enough attention to them. This may open the way to looking for alternatives that may not be expressly evaluated as more effective but may give a person a sense of receiving a more comprehensive response to their problem or more attention from the alternative medicine specialist.

Astin (1998) points out that there is no clear theoretical model to explain the increase in interest in alternative medicine. Expecting a uniform explanation in this context may be problematic because the causes vary for different aspects. Although there may be "something" that links those who prefer CAM, it would not be easy to identify what exactly it is. As mentioned above, it tends to be the case that people use CAM because their ideas about health are consistent with specific CAM ideas and/or because they are disillusioned with conventional medicine (Furnham - Vincent 2000; Barnes et al. 2008). However, it is one thing to map which alternative therapies people use and describe the reasons for their choices. Still, another is to determine how the (potentially) varied attitudes are interconnected, how the conceptual systems are (not) related, what explanatory frameworks they use, where the ideas and perspectives originate, and what role authorities play in the process of such ideas adopted.[9] In this context, medical anthropology makes use of the concepts of curing and healing, an explanation of which is necessary for understanding cases reported below.

Curing refers primarily to a biological process to eliminate pathologies or remedy physiological disorders. According to Waldram (2000: 602), healing is a "broader psychosocial process of repairing the affective, social, and spiritual dimensions" of impaired health. Those who seek out alternative therapies rarely reject biomedical treatment completely. An alternative procedure may be used for the part of therapy that could be described as healing. The concept of healing is not uniform – it is culturally determined, and it is often up to the healer what it applies to.

Healing reflects how a given illness is conceptualised in the broader social, economic and historical context (Waldram 2000: 605) and the personal trajectories of patients and their relationships with their surroundings (which may become part of the therapeutic process). This does not mean that all of us need to find causes in spheres going beyond the body's boundaries.

[9] It is a broad set of research questions; in this article we focus only on some of them (see the Introduction).

Additionally, not every patient expects an alternative therapy to make a problem simply "disappear" efficacy can also be evaluated based on whether an experience is interpreted differently or whether the patient learns to accept it.[10]

In general, it has been found that people use CAM because their ideas about health are consistent with specific ideas of CAM (so-called pull factors) and/or because they are disappointed with biomedicine (so-called push factors). Potential pull factors include (1) emphasis on control and participation; (2) perception of illness; (3) acceptance of holistic and natural practices and (4) a worldview reflective of unconventionality and spirituality (Furnham - Vincent 2000; Barnes et al. 2008). Amongst other characteristics of CAM treatments, there is less emphasis on "destroying" or suppressing a disease (via aggressive procedures such as chemotherapy) and more on stimulating the organism's "vitalizing, health-enhancing forces." The patient is not just the passive recipient of therapy but an active participant (Aakster 1986; Furnham - Vincent 2000). The push factors reflect, for example, the previously mentioned skepticism about the safety of substances used in biomedicine or the lack of attention from physicians.

Various studies indicated (Bishop et al. 2007; Kristoffersen et al. 2021; Lindeman 2011; etc.) the prevalence of women in CAM use, which was also the case in our research, where there are predominantly women of middle to higher education and middle to higher socioeconomic status. As Lindeman (2011) points out, variables such as gender, income, or education cannot theoretically account for the social aspects of interest in CAM. Still, they can explain the interest in health issues. According to Kemshet and Simchai (2014), the dominance of women in the CAM domain is related to empowerment: it is a way for women providers to earn financially, but it also gives them a sense of confidence and competence that they often lack in a male-dominated world. Feelings of confidence and competence stem from neoliberal ideology, which "emphasizes individualism and belief in the ability of any woman to act on her own and for herself" (ibid: 84). Women dominate in the use of CAM and the provision of CAM services (which tends to be associated with feminine qualities such as empathy, intuition, etc.).

The use of CAM can be positively associated with religiousness or spirituality, as shown by Heller et al. (2020). Several studies suggest a positive correlation between CAM use and reliance on intuition (rather than analytical thinking) and openness to new experiences (Browne et al. 2015, as cited in Demp et al. 2019). The study by Soveri et al. (2021), based on data from Finland, suggests that people refusing the COVID 19 vaccine are more likely to

[10] McGuire who studied Christian healing in the USA noted that "to be healed is not necessarily the same as to be cured. It is common to have received a healing and still have symptoms or recurrences of illness" (1991: 42-43, In Waldram 2000: 605).

share conspiracy theories, less trusting of sources that disseminate information related to COVID 19, and also more inclined to CAM.

Sample and methods

Our research is based on three sets of ethnographic data obtained in two Slovak towns from 2015 to 2018. Data were collected by all three authors separately. All researchers used the same methodology (described below). The research covered a broad set of topics; here, we present data analysis connected to the perception of used methods, mainly the reasons why participants chose them and how they value their effectiveness. Given the nature of the research, the research questions were relatively broad: we were interested in the reasons why our informants chose alternative therapies (including the selection of a specific treatment), their attitudes to biomedicine, their expectations from their treatments, their understanding of their efficacy, their attitudes towards the specialists in the CAM domain.

The informants were found via websites promoting their activities, social networks, and personal contacts. After establishing initial connections, other informants were obtained through a snowball method. If, for example, the researcher attended a collectively focused practice, she may have approached a number of people with whom she subsequently arranged a face-to-face meeting. The researchers did not know the informants personally before the research began, with a few exceptions. In this article, we mainly analyze data obtained through interviews due to the article's topic. To observe the perception of CAM treatments is practically impossible; it is reflected verbally, explicitly, or implicitly in the interviews. By implicit reflection, we mean talking about practices so that their efficacy is not directly discussed but appeared during the coding of the data. We do not comment on the effectiveness of CAM practices used by informants but analyze their attitudes towards these practices and the factors that influence their views.

During the field research, we focused on both individual and collective procedures. However, this is not of crucial importance here as we are analyzing mainly informants' view of used methods, regardless of the number of people present during them. We talked to women circles[11], ethics therapy[12], some variants of yoga, family constellations, traditional Chinese medicine, music

[11] As the name women's circles suggests, it is a form of therapy oriented towards women (at present, men's circles are also being established) including rituals, constellations and meditations, i. e. various techniques focused on the body and mind. The main idea is self-knowledge and a "return to the feminine essence".

[12] Ethics therapy is described as "treatment of habits" – bad habits, negative emotions, attitudes towards oneself and one's surroundings. It is based on the belief that everything negative begins on the level of energy and emotions and then manifests on the physical level.

therapy, aromatherapy, regressive hypnosis, meditation, spiritual response therapy etc.[13] Most of the technics were body-mind therapies. While women circles and family constellations are group therapies, ethics therapy or hypnosis is individual therapy.

Complementary and alternative medicine (CAM) is not regulated in Slovak law. Slovak laws[14] define health care as "the set of work activities performed by healthcare professionals, including providing medicines, medical devices and dietetic foods." The law establishes the category of healthcare professionals as individuals performing a healthcare profession. However, the law does not stipulate that health care must be provided exclusively by healthcare professionals. As a result, the law does not lay down precise rules regulating persons who provide health care without falling under healthcare professionals. Since Slovak law does not prohibit the provision of CAM, anyone can engage in this type of activity. However, the law does lay down clear consequences if a practitioner damages a patient's health.[15]

We analyzed data from 43 participants (divided among authors: 6, 26, 11). Age of informants goes from 26 to 57 at the time of research (approximately 30-50 in the case of the first author, 26-57 in the case of the second author, and 35-45 in the case of the third author).

In-depth interviews were conducted at the premises where the alternative therapies were provided, in cafés or other places the informants chose. The topics discussed included the life trajectories of the informants (their education and family background), then the problems that they were currently trying to solve, and why they decided on alternative therapy, their attitude to conventional treatments, how they interpreted their life situations and problems, how their current solutions related to their "philosophies of life" in a broader context, and issues related to the efficacy of the practices in question. The interviews began with general information about the informants, and they were then given space to talk about what they considered important. Other rounds of the interview focused on their attitudes to alternative methods as such, the problems they were working on, their perception of given methods,

[13] Family constellations are a form of alternative therapy used to address psycho-physical problems. Other therapies use meditation, herbs, music etc. that are supposed to influence bodily organs (and support their function, or to "synchronize" them) and the mind e.g., to support positive thinking, perception of life events, and influence general well-being.

[14] The law num. 576/2004 about healthcare, services connected to health care, an about a change and amendment of some laws; The law 578/2004 about healthcare providers, medical staff, professional organizations in healthcare and about a change and amendment of some laws.

[15] Consequences are regulated by the Criminal law (Law num. 300/2005, § 162): "If a person immediately endangers the life of another person, injure another person or perform without an agreement an investigative or curative act or incorrect indication of medicines, drugs or other medical devices and such an act endangers their health, shall be punished by imprisonment for a term of six months to three years. The offender is punished by imprisonment for 1 to 5 years if he commits the act in a more serious manner, or on a protected person. An offender shall be punished by imprisonment for three to eight years if he causes serious injury or death to the act in question."

and their own expectations, etc. Observations, if possible, were made at the locations where the activities take place. The informants had to give consent for the researchers' presence.

The informants had primarily completed secondary or higher education, and some of them worked professionally in alternative medicine.[16] They were mostly of middle or upper-middle socioeconomic backgrounds.

Women predominated in the study populations. This gender imbalance corresponds to CAM statistics worldwide (Harris - Rees 2000). This issue has been studied in Slovakia by Tatiana Bužeková, who researches neo-shamanic groups (Bužeková 2012).

All data were anonymized – names used in this text are not participants' real names. In the text, we present some verbatim statements of the informants. Their statements are illocutionary - they serve to supplement the argument. We believe that those parts are general enough and do not reveal concrete or personal information about our informants.

We based our data analysis on grounded theory (Strauss - Corbin 1998) and applied a three-stage coding of the data: open, axial, and selective coding. In the first-stage coding, we recorded everything related to the research questions, but at the same time some new themes "emerged". In the coding, we used in vivo codes (e.g., in labelling practices), or we use as a code the abstract concept that corresponded to the content of the utterance. In the next steps, we reduced the number of codes and combined the codes into meaningful units to create categories of codes. We tracked, for example, in what contexts informants mentioned the use of CAM, which led them to rate the method as effective (i.e., identify its impact on the problem they were addressing, e.g., my hair stopped falling out; I felt less nervous; my cycle adjusted; my eczema stabilized, etc.). The final step was to identify the relationships between the categories, e.g., informants' attitudes towards the practices they mentioned and situating these attitudes in their relationship with the healer; the way the illness narrative was shaped and situated in other life experiences, etc.

Perception of CAM methods, control and participation

Many contemporary alternative urban movements aim to personal growth and focus on internal rather than external factors in finding solutions. They promote the idea that people must process and solve their problems primarily by themselves. If responsibility is attributed to an external factor, the person should accept and come to terms with the finding and overcome it. On the other

[16] In this text we do not focus on expertise, neither we study legitimization practices used by specialists in the CAM domain.

hand, therapies may increase the sense of control over one's own health and life situations in general.

One of the essential questions for research on CAM is the perception of the efficacy of alternative practices. There are a few studies in Slovakia providing summary data on how the users of alternative therapies evaluate efficacy and what they expect from them (Bužeková 2019, Jerotijević - Hagovská 2019; Kráľová 2020). Alternative therapy users may have unreal expectations, and healers may make unrealistic promises, but this does not mean that the expectations of alternative therapy users are always and under all circumstances identical or that they accept them without criticism or reservation. Just as alternative medicine is diverse ideas and practices, its users are various people whose beliefs and attitudes about CAM may vary.[17]

Efficacy is an ambiguous concept that is not used consistently in practice. Young (1976: 5-24, quoted in Waldram 2000: 606) defines efficacy in terms of goals: "the ability to purposively affect the real world in some observable way, to bring about the kinds of results that the actors anticipate will be brought about." He conceptualizes medical efficacy as "the perceived capacity of a given practice to affect sickness in some desirable way," which may be understood as "curing" or "healing" disease. In Young's view, efficacy should be measured against at least three criteria: (1) empirical proofs, which are "anchored in the material world and confirmed by events that are explainable," (2) scientific proofs that are confirmed using scientific methods and (3) symbolic proofs, which cannot be clearly defined but increase people's ability to cope with the situations in which they find themselves as a result of illness. Although Waldram and Young talked about traditional medicine, we suggest that most of their claims can also be applied to alternative medicine.

As Waldram (2000: 610) observes, efficacy is related to non-efficacy or failure. People recognize when a method fails in practice; the variable factor is how they explain it. Waldram also raises another factor that affects the evaluation of efficacy. The timeframe in which therapy is evaluated – in biomedicine, it is often assessed moment by moment (the presence or absence of pathology). In contrast, alternative medicine may involve a long-term, practically never-ending process.

Based on their self-reports, alternative treatments might cause at least some of our informants to experience a recuperation of the physical and mental well-being that has been impaired due to their health problems. Conceived in this way, the alternative treatments may function as an aid to coping with their burden – the participants implicitly or explicitly hope that therapy will solve their problem. Still, they may consider it successful even when the primary

[17] This may seem like a trivial statement, but the examples from the Slovak media that we give in the text suggest otherwise.

problem is not solved. If the treatment is considered more as contributing to a "healing process," it is no surprise that the informants may consider it effective.

When people think about the effectiveness of alternative therapies, they need not use the same reference framework that they apply to biomedicine. In the present case, the treatments were mainly psychosomatic in nature. Their purpose need not be to provide a "cure" in the sense of removing the problem but rather to help participants "process" and accept their condition. In this sense, the informants may feel that they are actively dealing with their situation even if they do not arrive at a definitive solution. Eva, who is an alternative therapy provider, sums it up as follows:

> *When people come with problems, they have been fighting them a long time, and this is about energies, whose first rule is that whatever you pay attention to will grow; when you fight with something, it grows, so we don't fight. We work through acceptance, I don't have to understand it, but I let it be and increase my energy potential. When people come here, they have an energy deficit. I help them improve their energy potential…*

Informant Elena, whose husband was diagnosed with cancer, attended alternative therapies because she wanted to find why that happened. During spiritual treatment ("an Angel seminar"), she had the following experience:

> *…and then that Angel told me…I did not see his face; he was (hidden) behind a door frame… and he told me, "And You, why you came here? Go home and be thankful". That was a message from my guardian angel. And when I told that to my husband, he almost thought that I had lost my mind. So, I believe in these things, things between the Earth and the Sky. Because Angel has been right, my husband is doing well. I do not know what would happen if I weren't at that seminar.*

In described situations, alternative therapy helped the informant to "go" beyond (a negative) experience and see a problem in the broader perspective.

Sometimes, a sign that therapy worked was based on the context of the experienced situation, as in the case of Veronika, who felt anxious and sent her healer an SMS if she could help her:

> *…And about an hour later, I started to cry; it was an unreal cry. And then I was relieved. You just feel that it is not that bad anymore and as the stone had fallen from your hearth. And she had not even replied to my message. And when this happened (crying), I checked the message that I*

sent to her, and I realized that she read that message when I felt that relief. So, I just wrote to her, "thank you."

This does not mean that we did not encounter situations where informants explicitly wanted to solve a problem or improve their health. If, however, the problem was not solved/eliminated, an alternative explanation was found, and the process continued. Most of the respondents had a positive opinion of alternative treatments and said that they had had a positive effect on their physical and mental health. Some informants considered partial successes to be "proof" that a method worked. As noted above, Waldram described three ways of explaining efficacy. In some cases (such as the one above), informants did not directly expect the practitioner to provide a solution, but an explanation. They may have found the "answer" in a specific event they experienced, which they then interpreted in a certain way (for example, crying and then "relaxing" corresponded to the moment when the healer read the text message, which the informant interpreted as the healer's positive action "at a distance"). In these cases, the empirical evidence may be anything that informants evaluate in this way. The healing process, however, also takes on a deeper symbolic meaning.

It has been noted above that alternative medicine can be a long-term, sometimes endless, process, so it is challenging to talk categorically about success or failure. This applies especially to methods involving work with the body where the patient is an active participant and not "just" the recipient of instructions from the healer. In this way, the therapy takes on a specific spiritual dimension with elements of ritual (Jerotijević - Hagovská 2020). For example, Simona, who had a relationship problem, described constellations as follows:

It isn't therapy, but I don't know how I would describe it; it's not just an alternative way of seeking help, the group plays a big part in it, and it is really awesome with these girls. But I wouldn't call it therapy; it's more like a sort of learning. I could compare it, for example, to a theatre where you watch either your life story or the life story of someone else who has a significant effect on you and this type of theatre is also easier to follow. On the other hand, you don't have to have your own problems to participate in constellations, and you don't even have to find any. Even so, you can get a lot out of it.

Informant Denisa commented on the efficacy of constellations as follows:

They always work out in the end. Essentially, that final picture just shows where you could get to, but at that moment, you don't know

whether it is successful. That is the hardest part, which you might manage or not. You have to let it work on you and accept it because sometimes these things are complex, and a person may not want to accept the way things are, that they did something wrong and that it could all be their fault. So treatment is successful when you accept what you saw there in your heart, and you don't have to do anything about what you saw but simply not oppose it, and when the change happens inside you, you know it has been successful. Sometimes it can take a week, sometimes a month, it can take a year.

At the same time, discomfort can also be taken as a sign that the therapy has worked:

When the programs and burdens are vital, they can also become a burden on the physical level. It is expected that the mind and emotions are working, and the body gets tired. Everything gets tired, so it is normal that you feel bad… you are doing extra work emotionally, spiritually, and mentally. And the constellation keeps working even after it finishes. It's not a one-off experience.

The healing process acquires a somewhat symbolic dimension in our informants' experiences. This is in accordance with Csondras (1988), who suggested that if we see the process of healing through a symbolic perspective, it does not have to lead to the elimination of physical problems but towards a transformation in the perception of the problem or towards a change in the lifestyle.

Mária (29), who faces cancer as nineteen years old, evaluated her experience as follows:

[Before] I was not interested in the needs of my body and my soul. I did not think about it. I went with the flow as a sheep. I was too materialistic; I used to shop a lot. I did not take care of myself, my health, my lifestyle, I had completely different values, and it took time until I understood some connections…And the healer helped me in that. She, so to say, opened the gate towards deeper perception for me. Even though I know that I still have cancer, it will never go away. But I feel fine, and I think it is mainly because of the therapy.

The alternative medicine perspective does not necessarily conceptualize the disease itself differently. Informants are aware of the biological causes of the

conditions they are confronted with, but their explanations go beyond biological causes. They may accept biomedical explanations and undergo biomedical treatments. However, they want to know "why" things happened. We see in the above examples and many others "narrative creation. " Using it, otherwise unrelated events are linked together to form a continuous, recurring sequence of events. Data analysis showed the construction of a narrative concerning the problem: how the problem occurred, how it manifested, what was done to solve it and with what effect, what was the current state of the problem solution, what meaning was attributed to the event. It is the shaping of the narrative that is one way of coping with the problem. However, this narrative is not formed in a completely random and undirected way as we will show below.

Persons seeking alternative methods often emphasize communication with a CAM specialist. Several informants highlighted that the first visit to a CAM specialist lasted an hour or more, something they had rarely encountered in biomedical practice. Already during this first visit, the different aspects of the problem to be solved are discussed and the links between them are pointed out. The specialist is an essential part of the treatment process, as they diagnose and prescribe the treatment procedure and help understand the nature of the problem the person faces. Informants emphasized the empathy of healers (often in opposition to the impatience and "coldness" they knew from biomedical practice). They actively participated in decisions about other practices and often emphasized the "energetic connection between themselves and the healer." It is in accordance with a study from Denmark (Pedersen et al. 2016) that shows that CAM users appreciate that CAM providers are "caring, listen attentively and give relevant feedback." Shared decision-making about treatment is also crucial for the patient. Stöckigt et al. (2015), based on data from Germany, show that patients using CAM described their relationship with their healer as "unique." In particular, the healer's 'empathy' was important to patients. Similar to the case of our informant Veronika mentioned above, participants described a "connection" or "connection through energy" between themselves and the healer.

One of the crucial moments in the healer/patient interaction is the acquisition of meaning, or rather, understanding (finding) the essence and cause of the problem. The healer connects body and mind and often connects both with the transcendent (Stöckigt et al. 2015), which can take different forms in CAM (at the same time, not all CAM methods involve the transcendent or spiritual dimension). Several studies have pointed to the importance of the therapist/patient relationship on therapy success (Rogers 1965; Balint 1957, as cited in Stöckigt et al. 2015). Implicitly or explicitly, our informants emphasized the therapist's role in solving their problem, as is also

shoved in their quotations. The support they felt from the CAM specialist and the opportunity to discuss aspects of their lives other than their illness was essential to them. While the person is describing they own experiences, it is the healer who connects these experiences and sees them in a broader context (depending on the healer's focus, interpretations may also be anchored in experiences from "previous" lives if problems are interpreted as "karmic debt", etc.).

According to Frank (1995), people comfortable with a health problem tend to construct a narrative regarding their illness. Frank defined three types of narratives: the narrative that describes the state of affairs (yesterday I was healthy, today I am sick, but tomorrow I will be healthy again) and expresses the expectation that things will get better (*restitution narrative*); the *chaos narrative*, which expresses the belief that things will never be the same afterlife has been disrupted by illness; and *the quest narrative*, which presents the experience of illness as a challenge that will ultimately make the person stronger. We argue that healer-patient interaction plays an essential role in forming narrative - or, more specifically, positive narrative (type 1 or 3). The healer is the one who suggests why the health problem occurred and "guides" the patient on how to deal with it. The narrative formation may be supported by other social factors since, as was the case with our informants, informants do not live in isolation but usually associate with persons with similar life philosophies and are "affirmed" that their current attitude towards the health condition is "true" (see also Jerotijević – Hagovská 2020).

The creation of an illness narrative is not only occurring among CAM users. Even a person who will not choose alternative treatments may have a need to contextualize their experience (see, e.g., Luker et al. 2006). How a person will interpret the illness experience depends on various socio-psychological factors. However, seeking to understand the lived experience is not surprising. According to psychologists Folkman and Lazarus (1988), seeking information about the problem with which the person is confronted (it need not be just the illness) is a *vigilant coping strategy*. Although more knowledge may not always bring relief (e.g. the problem may turn out to be intractable), in many cases, understanding the problem can increase the sense of control (Folkman – Lazarus 1988: 311-312). From a psychological perspective, information seeking indicates a desire to solve the problem (ibid). This is why an alternative method that gives specific meaning to the lived experience can be perceived as successful even if it does not have a direct impact on the elimination of the problem.

It is important to stress that studied methods (or healers/specialists) did not claim that their methods are a substitute for biomedical treatment, especially in the case of serious illnesses. As Kráľová (2020) argues when facing a severe

illness, they face physical pain, anxiety, and affliction; illness impacts the social and economic domain and influences whole families and social networks. Non-alternative treatment claims to solve these problems but (from the emic perspective) helps to (at least to some extent) to re-establish life equilibrium. To a greater or lesser extent, alternative treatments may play an important role in how participants perceive their situation and can have a positive effect on their well-being. The participants' (negative) experiences were ascribed a deeper meaning, which enabled them to be transformed into neutral or even positive experiences. The participants in such therapies acquire a sense of active engagement with their problems and search for solutions, affecting their overall well-being.

If the used method was evaluated as ineffective (e.g., an informant had a clear expectation that did not come true), it usually did not lead towards complete refusal of CAM. Ineffectiveness should be a consequence of healers' insufficient experience with the concrete problem of inexperience in general or result of his/ her bad intentions; client's unpreparedness to face a problem etc.

Conclusion

The present work aimed to point out how users of the CAM method approach and perceive them. CAM users may consider the CAM method effective even when they do not remove a problem (with their health or other areas). Alternative therapies may represent a form of coping, i.e., managing stress while also offering people the feeling of actively contributing to the solution of their problems and giving them a sense of control over their own lives (Folkman – Lazarus 1984). The group of people with whom the participants share their personal experiences also plays a part in the overall evaluation of therapies. In general, efficacy is not evaluated based on the definitive elimination of a problem but on its "acceptance," or, as some cases indicated, the sharing of experience with others. A CAM specialist may play an essential role in this process.

The study is based on qualitative methodology and has some limits; for example, it was not possible to follow up with informants and track changes in their attitudes over a more extended period. It is evident that "building" a particular view of the world ("philosophy of life") is a long-term dynamic process involving many factors that it is difficult to "map" with the methods used in this work. The informants' testimony clearly indicates that they hold various ideas that they "lean towards" depending on the context.

Most research on CAM use shows that only a small number of people opt exclusively for alternative methods. They often consider these methods complementary and combine them with biomedical treatments (Stöckigt et al.

2015; Fjær et al. 2020, Wemrell et al. 2017, etc.). Studies by Kemppainen et al. (2017) or Wemrell et al. (2017) show that the reason for choosing CAM may be overall well-being or an improvement in quality of life. Although we do not claim that people choose CAM without the expectation that this treatment modality will contribute to disease elimination or help to stabilize the disease, this is not necessary for a positive experience with CAM. However, this does not mean that CAM users approach CAM methods uncritically. Their positive evaluation may result from a positive experience of communication with the healer and, consequently, treatments that put the patient in an active position and give them a sense of participation in the treatment, which is often lacking in biomedical settings.

People who use alternative medicine accept biomedicine but tend to combine conventional and alternative therapies and demand the "right" to choose how they are treated. The extremes that can be encountered in, for example, Russia (Lindquist 2006), are the exception rather than the rule here.

Critical discourse aimed at alternative medicine users often includes another, not entirely clear, assumption: CAM users are somehow implicitly expected to consistently review and analyze their attitudes from different perspectives.[18] However, this is not a characteristic of everyday thinking (Young 1976) and not only in the case of CAM users. "Systematic reasoning" on an analytical and critical basis is typical of expert behavior: it involves looking for (alternative) solutions, looking at problems from several angles etc. On the other hand, everyday reasoning is based on solutions/understanding of routine situations. It is more intuitive and spontaneous and needs not to consider different solutions – it is usually the approach that is (for various reasons) most relevant to us. For CAM users, a specific solution may seem most reasonable (applicable) in a given situation, but this need not mean (and it very probably does not mean) that they never review their attitudes, reject some of them, and so on.

It can be said that different approaches perform different functions in respect of a health problem and therefore raise different expectations and are evaluated in another way. Health problems raise many questions, and we may not find relevant answers to all of them. Poor health affects all spheres of life and can increase stress and anxiety. People are more likely to ask themselves, "What's happening? Why is it happening? Why me?" The search for answers that conventional medicine does not provide (because they are outside its scope) and the search for "hidden" meanings in one's experience gives a feeling of control over events and makes them at least somewhat more comprehensible

[18] This attitude can be encountered quite often in the Slovak media, see e.g., https://dennikn.sk/1575296/sef-lekarnikov-homeopatia-nefunguje-homeopaticke-lekarne-su-problem/?ref=list; https://dennikn.sk/blog/172534/slzy-v-ociach-alternativnej-mediciny-na-slovensku-boli-utrete/, etc.

and bearable for people. Alternative therapy can provide a sense of actively "fighting" a problem, which can also help reduce the stress and anxiety caused by a condition. Therefore, the use of alternative therapies need not necessarily result from people's ignorance about biomedical procedures or the fact that they consider them irrelevant, but rather that they see them performing a different function. If people are confronted with an unexpected diagnosis in a child, psychological disorders in their loved ones, sudden death in the family or infertility without clear causes or the like, they may try to find what has given rise to this condition, and biomedical explanations may not satisfy them in this regard. The reason is that they are statistically based and generalized, and people tend to want specific, tailor-made answers. Thus, when people use different methods of explanation or combine other treatment methods, it does not mean that they reject conventional medicine but that they consider its explanations and procedures to be insufficient because the questions they are asking and the answers they seek are outside the conventional scope.

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