Advocacy and Activism in Complementary and Alternative Medicine Research: A Croatian Example

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**ABSTRACT:** In this paper I explore the link between research into contemporary alternative medical practices (CAM) and activism. It is based on my recent research (2004–2007) which dealt with the interrelatedness and coexistence of biomedical and non-biomedical systems in the city of Zagreb. The process of adoption and introduction of CAM to Western European countries started some twenty years ago and in Zagreb the process was evident after the fall of communism. My research started with patients and their attitudes towards illness, health, well-being and suffering, factors that determined their choice of therapies and healers. However, hearing stories of people’s experiences of CAM propelled me into the role of therapist as listener and, through attending to the silence surrounding the use of CAM in a relatively hostile society, the role of anthropologist as activist. Through the process of understanding and interpreting sensitive cultural practices, I explore whether anthropologists are uniquely placed to actively protect the rights of people to whom they owe their science.

**KEYWORDS:** complementary and alternative medicine; activism; ethnography; Croatia

**Introduction**

Different types of complementary and alternative medicine (CAM) have become an unavoidable item on offer in Western health care markets and a part of everyday cultural life. Shops, products, schools and practices of different forms of alternative medicine have been present for a couple of decades in all European cities. According to the World Health Organization (WHO) (www.who.org) by the end of the last century roughly 20 to 30 per cent of the population of Western Europe have used different forms of CAM, with 70 to 80 per cent of the population interested in their health insurance covering some forms of alternative medicine (Gazdić and Šinkovec 2002). This phenomenon of coexistence of several therapeutic practices from which patients (clients) can choose freely, defined as medical pluralism, is today considered to be the dominant characteristic of postmodern medical reality in the majority of the world countries (Leslie 1976; Helman 1984; Kleinman 1980; Benoist 1996; Hsu 1999; Krausse 2006). In Zagreb, the capital of Croatia and its largest urban centre (1.2 million people), alternative medical practitioners and practices are now visible in everyday life: shop windows, newspaper advertisements and articles, and TV shows. Whereas the process of adoption and introduction of CAM in Western European countries started some twenty years ago (Benoist 1996; Hsu 1999; Cant and Sharma 1999), this process only became evident in
Zagreb after the fall of communism during the late 1990s and the introduction of a market economy.

The following arguments on the link between research into CAM practices and activism are based on my recent research (2004–2007) which dealt with the interrelatedness and coexistence of biomedical and non-biomedical systems in the city of Zagreb. My initial research showed that patients’ attitudes towards illness, health, well-being and suffering determined their choice of therapies and healers. I looked at which factors (cultural, social, generational, educational, religious, political-ideological, financial, emotional) determined their choice: whether people were using CAM just for specific reasons; for some diseases but not all; in specific situations in life; and whether it was a ‘new’ cultural fashion. Most local research into other medical systems comprises of descriptive ethnographies, so in this research I used theories and methodology from medical anthropology (Kleinman 1980; Helman 1994; Scheper-Hughes and Lock 1987; Leslie 1976; Eisenberg et al. 1998; Eisenberg and Kaptchuk 2001a, 2001b; Hsu 1999).¹ To find my first informants I started with HUPED (Croatian Federation of Natural, Energy and Spiritual Medicine (CFNES)), the largest organization of alternative practitioners and healers. The organization was founded in 2000 and is the only professional organization of CAM healers and practitioners in Croatia. It has around 400 current individual members (healers and practitioners) and another 2000 members who have joined via smaller associations (association of reiki practitioners, acupuncturists, different new age groups, etc.) Using the snowballing technique, I started with the president of the organization and sampled out ten healers who wanted to participate in the research. I then conducted semi-structured or, in the majority of cases, open-ended interviews, with ten clients of each of these healers and shorter, semi-structured interviews with the healers themselves.

Post-socialism: The Changes in the Health Care System and the Onset of an Activist Society

As in other East and South-East European countries, the post-socialist period in Croatia started in the 1990s and brought about significant changes to the official health care system. Before the 1990s, the dominant health care system was state funded. Most employed people and their families had access to all hospitals, university clinics, day-care clinics, etc. For those paying the state-determined and more or less unified health insurance as part of their salary, all services were free. Private clinics and doctors were almost non-existent, although during the late 1980s a few private dentists and gynaecologists had started working in Zagreb, used by a small wealthy elite.² Alternative forms of health care started to appear in the early 1970s in the urban regions (according to some of my informants, the first example was a small practice in homeopathy opened in Zagreb in 1973), but their number was too small to make any serious impact on health culture during Croatian socialism. Some forms of traditional medicine were used and practiced in remote rural regions, but silently and very locally.

After the 1990s, the once exclusively state-funded health care system became more market oriented and consequently expensive to the end users, the patients. The sheer idea that you had to pay for just going to the GP (the so-called participation) was quite surprising, almost shocking for most people. The number of private doctors and specialists increased rapidly and private practices rose in number from a few dozen to several hundreds (paediatricians and dermatologists in particular). A significant number of large private clinics have also opened all over Croatia in the last ten years. The prices were by no means low.

Simultaneously, and maybe as a result of this expansion of private practice, non-biomedical practitioners, ranging from folk healers, herbalists, exorcists and bioenergy practitioners to
the practitioners of more established non-Western biomedical systems such as ayurveda, acupuncture, homeopathy, reiki, and other relaxation and stress-relieving techniques, also became more ‘loud’ and visible. These alternative practices developed a greater profile in the media and were discussed more in everyday life. Politicians or celebrities who went to this or that practitioner were judged or praised. For example, the former Slovenian Prime Minister Janez Drnovšek came under scrutiny for allegedly paying his ayurveda therapist, who came from Switzerland, with taxpayers’ money.

So what is the specific ingredient of the post-socialist context that contributed to the sudden upsurge of CAM? Socialism as the leading state ideology was firm in imposing its own power structure and modes of thinking and behaviour as the only valid one. The state economy would rely on state (medical) education and employ state medicine. A firmly established and unquestionably empirical and scientific health care system just increased the state’s validity and strengthened its position and its absolute authority. The non-existence of a market economy and consumerism meant that one’s choices in life were limited, and the artificially created shortages during the late 1970s and early 1980s (of coffee, petrol, detergents) were intended to encourage appreciation of what one had, including medicine. Thus a dogmatic, ideologically strong, and firmly established medical system reflected a state ideology that was also right, strong and valid. My older informants were always emphasizing how ‘other’ medicines, such as herbalism (which was part of Croatian traditional medicine), could never be practiced lawfully but only under the counters at urban markets or in rural areas, and were actually banned as a result of the socialist ideology.

Thus the rising of the ideological curtain may have made these choices of different ways of thinking and modes of behaviour even more attractive and desirable in a cultural context where choices were curtailed.³ This can also be said of choosing medicines other than mainstream biomedicine. In the words of one of my younger (twenty-year-old) informants, also a gay activist: ‘Choice of another therapy is one of the basic human freedoms, I want to chose whom I love and I want to chose where I go for healing’. The introduction of the market economy also raised awareness of being given value for money. This attitude that was absent from socialist ideology and socialist thinking, but people are now asking for a medical output for their monetary input. Many of my informants who had prolonged (over five years) experience in using CAM said that they felt that they were getting what they came for and that that was the main reason why they continued to use CAM practitioners.

Post-socialism also brought about a rise of civil society. Advocacy and activism has only become a prominent part of everyday culture in Croatia in the last ten to fifteen years and the most numerous civil rights groups are those fighting for women’s rights, environmental protection, gay rights, and more recently, increasing numbers of new age groups and centres. Some recent discussions of CAM (Goldner 2004) define it as a form of social movement, a type of activism, where both practitioners and clients are seen as activists forming ‘a seemingly cohesive social movement that challenges Western medicine collectively’ (Goldner 2004: 711). Goldner argues that therefore research and discussion on alternative medicine should actually avoid the institutional and organizational theories and analytic designs which are employed in a clinical, biomedical setting and health research in general. There are a few points to be discussed here regarding CAM in Croatia. First, according to my research findings, CAM is by no means a cohesive social movement. Differences between different medical systems, practices and the adjacent beliefs and notions are large (systems of spiritual healing and, for example, acupuncture can hardly be compared), even though their epistemological opposition to Western medicine is an element they all share.
Secondly, most of the CAM clients do not perceive themselves as activists at all (92 per cent of my informants) or as advocates of a specific way of life; they were simply seeking help which they felt was unavailable elsewhere (in biomedicine). The view that CAM should be perceived as a form of activist social movement was also strongly opposed by my informants from the CFNES. As one informant expressed:

Milder forms of alternative medicine such as yoga and new age groups could be seen as social movements advocating specific lifestyles and philosophies, because their primary aim was not to heal a person who is in need. All other systems are health care systems because people decide to use them when they need to be healed or cured, when they are looking for the meaning of life.

Therefore, I would argue here that activism is not at the core of CAM practices, but that it can be a possible or a probable outcome of CAM research which aims to establish an explanatory framework of the different ways people perceive their health, diseases, illnesses, discomforts, and which cause them to choose differently. Finally, I would agree with Goldner (2004) that research into CAM requires something other than health research in general. However, I would carry this point a bit further to claim that the qualitative approach to health research in general—which would include patients’ stories and their analysis (Kleinman’s (1992) ‘illness narratives’ or ‘mini-ethnographies’) as well as the broader context—would be a better approach for any health research.

Sense, Sensibility and Spirituality in Alternative Medicine

As far as combining biomedicine and CAM is concerned, for the majority of the people I interviewed biomedicine came first, both chronologically and conceptually, but in case of chronic, terminal or psychosomatic illnesses, they sought alternative therapies ranging from folk healers to established non-Western medical systems. However, my informants with prolonged positive experience in CAM claim that they would primarily rely on CAM.

I was surprised to find out that the choice of therapy and therapist was rarely based on careful reading, internet checks or some other form of obtaining information, but on a feeling, a hunch. Most of my informants spoke about seeing a therapist on TV or reading a sentence from a newspaper advertisement and decided in an instant to call her/him. If asked to explain their decision in more detail, they would just say that they ‘felt something’, a feeling that made perfect sense to them. They would seek further confirmation of his/her competence in the initial ‘diagnosis’ with the healer. If the healer’s diagnosis and the description of the cause of illness made sense, they would consider this definite proof that they were at the right place. Most complained that biomedical practitioners did not tell them exactly what was wrong, whereas CAM practitioners provided a detailed explanation of the problem: where the energy blockage existed, what stress caused it, what situations in life they should avoid and how they should behave in order to achieve a healthy, happy life. Those who felt that such explanations had made most sense, felt the most satisfied with their healer and seemed to be the best ‘cured’.

Alternatively, the second most common way of choosing a therapist was through word of mouth: somebody would recommend to their friends/family a therapist who helped them. If that person was a family member or a close friend whom they considered credible and trustworthy, they would listen to their advice.

No specific conclusions could be made regarding the diseases for which my informants sought help from alternative practitioners, which were varied and ranged from diabetes (both types), multiple sclerosis, mental retardation, impotence, inability to conceive, death of a spouse and related Post Traumatic Stress Syndrome, hyperthyroidism, psoriasis, and a
large number of cancer patients (who formed a special group and about whom the healers themselves admitted that they all use CAM as the last resort). However, the majority of my informants felt that their conditions included something more that just a disease. They felt that CAM was the place where this ‘something else’ could be treated and were fairly confident that biomedicine would not even notice this ‘surplus element’, the X factor. Although most of my informants would not name it, some called it ‘the soul’, some ‘my inner self’, and some simply ‘God’. To some it was enough that CAM would admit that the death of a spouse which happened almost two years ago could still be a cause of serious and devastating illness, something biomedicine would dismiss with anti-depressives, and actually take away the possibility of the patient taking control of her own life and life choices. And finally, most of my informants simply sensed the need for a specific CAM practitioner who would help them solve a problem they felt they had, but which biomedicine did not recognize or to which it did not have a solution. Most of them spoke about a changed state of consciousness and an improved state of being as a consequence of seeking and obtaining CAM’s help. The most satisfied were the ones whose idea and notion of their illness (their explanatory model) dovetailed with the one offered by the healer. If asked whether the explanation of their condition offered by the biomedical doctors seemed equally plausible to them, they said that all they were hearing about in biomedical settings were the consequences of their state, not its cause.

Kleinman (1980) has suggested, in a classic of medical anthropology, that all participants in a medical system (patients and doctors or clients and therapists alike) have explanatory models. However, by adding to this claim Foucault’s (1973) idea of doctors and patients being an unwanted disturbance in the clinical process of imposing a naturalistic medical gaze over the human body and establishing a one-way empirical correspondence between symptoms and outcome, we get closer to my informants’ experience of the biomedical consultation: that the explanatory models of doctors, even though existent, and those of patients, expecting more, were put aside and played little or no role in the doctor–patient interaction.

No strict conclusions about the social status of individuals using CAM practices could be made. Men and women were present in equal numbers, the youngest patient I spoke to was twenty (and I spoke to a grandmother who brought her three-year-old daughter to a practitioner) and the oldest from the sample was seventy-five. Most people were aged between thirty and fifty. Most were college educated or high school graduates.

A Different Kind of Ethnography

All the above-mentioned data were obtained through prolonged, very detailed and sometimes very emotional interviews. As an ethnographer, I was faced with moving stories of loss and trauma, stories of war refugees, patients with Post Traumatic Stress Syndrome, disabled people, people who had lost their loved ones, as well as stories of miraculous healings and becoming well again (feeling like being born again, having energy again, being again able to get up in the morning, being able to walk again) which made me reexamine my position of observer, interpreter and analyst.

All the time during interviews, I felt that I was trying to make sense out of other people’s sensibilities and their most intimate feelings, notions, desires and beliefs, and I would sometimes wonder whether that was a futile task. My informants would talk about intuitions, hunches, ‘sensations deep down’ or changed states of consciousness. They would frequently describe how things that they could not explain or understand made them feel. Yet I could not think of another way in which it would be possible to understand human notions of health,
illness, disease, well-being, pain, suffering and happiness in all their complexities and sub-tleties rather than through doing qualitative research and in-depth ethnography, defined by Joralemon (1999) as ‘an essential tool to understanding human suffering due to disease’ in alternative and biomedical settings alike.

Sometimes I realised that what all my informants really wanted was someone to listen to them, as some of them plainly told me, and so in a way I was participating in the creation of the same process I was actually investigating. This idea of the therapeutic aspect of trauma telling has been discussed before (Schwartz and Prout 1991; Herman 1992; Eagle 2000; Kaminer 2006) and many psychological studies show the healing aspect of retelling one’s trauma (Foa and Rothbaum 1998; Marshall et al. 2000). But some of my informants were also sceptical about sharing their CAM experience with me, as the status of CAM in Croatia is still relatively negative. According to the majority of my informants, they were not likely to discuss visiting a CAM practitioner with others, other than immediate family members. They said some might consider them to be ‘fools’, ‘lunatics’ or ‘Satanists’ and practitioners as ‘witches’ or ‘wizards’. I myself witnessed such attitudes on several occasions when participating in a pilgrimage-like mass visit to the most popular spiritual healer in Zagreb: the participants in the procession were aggressively verbally attacked by the people on the street. Not all reported such strong abuse, but all were uniformly dissatisfied with the public image of CAM in contemporary Croatia.

There thus appears to exist a kind of paradox between the visibility of CAM and the recent popularity of it, as mentioned earlier, and the negativity and lack of openness about going to a CAM practitioner. This might be explained partly by the fact that the process of introduction of CAM to Croatian society is recent (there is no legal framework for any kind of CAM in Croatia); that it happened after the period of socialism which was unfriendly to alternative modes of thinking; and that it is being introduced into a society in which the growing dominance of Catholicism, silenced during the socialist era, adds to an uneasiness with different ways of thinking and believing.

Towards Advocacy and Activism in Alternative Medicine Research

This is where the activism steps in. Or in the words of the President of CFNES:

Sure, what I do is activism, but only in so much as I am helping the alternative practitioners and others from that realm to get a fair position in society, in the academic community ... [and] not because I adhere to a specific worldview. People who practice and use alternative medicine are not medical minorities, [since] alternative medicine is much more present than it seems. And they deserve to have their rights ... and [also] for all the health care systems to be treated equally—the same as biomedicine. ... It is also a big question for consumer protection ... here we have to work with NGOs dealing with consumer protection to protect our clients ... it is not like that in the West ... [since] alternative medicine there has a more normal position than here, they don’t need that.4

My path towards activism in alternative medicine was, similarly, completely coincidental. I did not intend to engage in activism nor did I design my research around studying activist groups, because as previously argued, varieties of alternative medicine are primarily health care systems and not social movements. However, the prevailing attitude of my informants that they were stigmatized because of stating openly that CAM helped them, made me more inclined into thinking that a certain type of advocacy should lurk behind every anthropological story. This is by no means a novel idea in anthropology. The idea of militant anthropology (Scheper-Hughes 1995) has already raised the question of the need for the active involvement of anthropologists in the ‘post-produc-
tion’ of their research. What I found interesting in this particular case was that militant anthropology seemed to be a logical continuation and not necessarily a theoretical or epistemological standpoint of my research (or definitely one I did not see coming). It led me to participate in all the current activities of CFNES by providing my research findings and playing an advisory and consultative role in the construction of the first higher education institution for alternative medical practices in Croatia. One of the first steps in this construction will be to start a dialogue between academia, scientists and civil society, and also between civil society and the state institutions (Ministry of Health of the Republic of Croatia) dealing with health policies. We will do that by organizing a congress on cooperation between clinical and unconventional medicine in June 2008. The aim of the congress is to bring together biomedical doctors, experts and practitioners of unconventional medicine, social scientists dealing with health and medicines and health policy makers and establish a framework for the future coexistence of different types of medicines for the sake of better health for all.

One of my favourite sentences in anthropology is Ruth Benedict’s (1934) explication of anthropology’s purpose: to make the world safe for human differences. Anthropology’s unique possibility of understanding and interpreting other cultural norms and realms and its application to this very sensitive field of health and illness, which is full of emotional attitudes, opinions, beliefs, metaphors and meanings, may, in the case of applied medical anthropology, suggest a necessary shift towards activism and more active involvement of anthropologists in protecting the rights of people to whom they owe their science.

Notes

1. This process of introducing sociocultural anthropology (and its subdisciplines such as medical anthropology) to cultural research in the universities and institutes all over South-Eastern Europe began in the 1990s. Even though the reasons for this are beyond the scope of this article, it is important to mention here that in-depth research of one’s own culture has been present in South-Eastern Europe since the late eighteenth century. The subsequent political developments in nineteenth century Europe brought about this rural and national orientation within the discipline of ethnology, but today culture research in South-Eastern Europe is again becoming as diverse in scope, research methodology and theories as its Western counterpart.

2. Generally, using their services was considered to be snobbish and posh. This is just an insider’s perspective of a person living within a socialist state at that time, but I clearly remember the names of three popular Zagreb dentists from the late 1980s (probably there were no more) and my mother explaining that only the descendants of Zagreb ‘aristocracy’ would ever go there. ‘Normal’ dentists were considered to be ‘just fine’.

3. Simple everyday life choices were limited: food, clothes, cars, books. I still remember my childhood fascination with Bounty and Snickers chocolate bars which we bought in neighbouring Austria during obligatory shopping trips to small Austrian border towns which we would undertake twice or three times a year. Everything that was ‘worth possessing’ had to be bought in the ‘West’.

4. CFNES is now working on establishing a legal framework for CAM in Croatia and has already composed a draft of an Act on CAM which has been passed to all the Parliamentary Parties for further discussion during October 2007. The research described in this article might help provide scientific insight into the problems and issues concerning CAM users and practitioners.

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