# The Shamanic Model of Illness and Healing applied to HIV and AIDS

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In recent years the experiential psychology of indigenous peoples, those living in tribal social groups, has become widely known. In particular, the role of shamans, healers who mediate between the mundane everyday world and the realms of spirits, has introduced a 're-discovered' perspective in psychology. Shamanic practitioners have, for thousands of years, employed models of health and illness which integrate the physical, the psychological and the sacred. Indeed the tribal societies of early 'dark age' and medieval Europe, when we too were 'indigenous people', subscribed to these same holistic models of medicine.

But as western medicine discovered ever more powerful drug-based treatments, our understanding of the psychological and in particular the spiritual factors of health correspondingly faded. Today, faced with disease systems that either do not readily respond to our drug medicine, or else respond with damaging side effects, our attention is being redirected toward the psychological fac-

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tors in the etiology and treatment of illness (we still have a long way to go before western medicine feels impelled to reconsider the spiritual dimensions).

In coping with some diseases — for example HIV, the focus of this paper, we have introduced a number of ways of diagnosis, counselling, therapy and treatments which are humanistic in nature, and alternative or at least complementary to mainstream drug-based medicines. But often these approaches are introduced ad hoc, seeking pragmatic results under difficult circumstances, and the new perspectives are not connected to an overall model of humanistic medicine.

The rediscovery of shamanic medicine may help us to integrate current piecemeal developments in complementary therapies into an overall model, one which, while less developed pharmacologically than the rest, is nevertheless highly sophisticated with regard to the psychological factors in health and illness.

Among the groups increasingly using complementary and alternative healing practices are people with Human Immunodeficiency Syndrome (HIV) — the virus which may lead to Acquired Immune Deficiency Syndrome (AIDS). In this article we will consider how many of the 'alternative' therapies used by people with HIV are consistent with shamanic healing practices, in the belief that the shamanic framework offers a psychological context in which HIV therapies may be more clearly integrated. In this context we shall explore the models of illness employed by shamans, especially in areas where shamanism and western medicine coexist, and the difficulties and symptoms which may accompany a positive HIV diagnosis.

In any paper on AIDS and HIV, constraints are imposed by the issue of confidentiality. We have quoted from people who are antibody positive without identifying them, except in one or two cases with the consent of the person concerned. We use the terms HIV+, antibody positive (ab+), sero-positive and sero-converted interchangeably, while 'Arc' (AIDS Related Complex) and 'Aids' are used for people presenting with symptoms, or the symptoms themselves, as defined by the Sussex AIDS Centre and Helpline.

## *The Nature of HIV within a Shamanic Perspective*

General awareness of HIV is now high, but it may be useful nevertheless to begin with a brief description of what HIV is, and of some of the commonest emotional and physical problems associated with a positive diagnosis. It is important to note, of course, that not every antibody positive person experiences all, or even any, of the effects mentioned.

The Human Immunodeficiency Virus is transmitted through body fluids: blood, semen, cervical fluid, and possibly breast milk. The easiest routes of transmission for the virus are through blood to blood contact, which is common among intravenous drug users who share needles and/or syringes, and through penetrative anal or vaginal intercourse. Once the virus enters the bloodstream, it causes a breakdown in the immune system by attacking certain T lymphocyte cells, leaving an antibody positive person vulnerable to infections which would not cause problems for someone with an intact immune system. Also, because HIV is

a retrovirus, and can, therefore, convert its own RNA and DNA, the virus can adopt the genetic makeup of the cells it attacks.

This has two main consequences: firstly, when the immune system 'switches on' and the host cell reproduces in response to an infection or illness, the virus is also reproduced and then attacks more T cells; secondly, because the virus becomes part of the genetic structure of the infected cell, it cannot be killed without destroying the host cell. HIV is, therefore, likely to be present for life, but may not necessarily be regarded as a terminal illness. On present figures for known cases, 70% of sero-positive people have not developed AIDS.

In its early days, HIV was widely regarded as a problem primarily affecting homosexual men and injecting drug users — two groups who are still seen as social outcasts by many people. The issue was sensationalised in the tabloid press and people with AIDS were often ostracised. Because of the perceived link with AIDS, a positive HIV diagnosis is often accompanied by emotional and psychological traumas associated with fear (of death, rejection or stigmatisation), guilt, anger and feelings of powerlessness. Antibody positive people may present with a range of symptoms, from weight loss, night sweats and persistently swollen lymph glands through to the many opportunistic infections, such as Kaposi's Sarcoma and Pneumocystic Carinii Pneumonia, which characterise full blown AIDS. Most of them experience, no matter how briefly, a feeling of loss of control and a conviction that a positive test result equals an imminent death sentence, and this changes their perceptions of life.

For most people 'life is based on the assumption that they will live to old age. With the illusion of the time to spare, their lives lack urgency, intensity . . . Thoughts become clouded with images of future events and the actions and emotions of the moment are postponed indefinitely.' This quote from Wulf, the Anglo-Saxon shaman in my (Brian Bates') *The Way of Wyrd*, echoes a sentiment often expressed by people with HIV. Someone once described the virus to us as 'life-changing, not life-threatening', and one 26-year-old antibody positive woman commenting on the above passage observed: 'The future is so uncertain, I want to cram everything good into the shortest possible time. I want to make sure that if I became sick I'd have lots of happy memories and no regrets.'

Wulf continues, in the same passage: 'The warrior must accept deep within his heart that one day he will be dead and that day could be today. The greatest fighters live as arrows, not targets. The arrow speeds through space cleanly, swiftly, directly, alive and moving, it has direction and an end point, but in between it soars. The target merely stays still, waiting for something to happen.' This elicited the response from the same woman: 'Also, it's important to know I'd met the challenge head on, I'd succeeded in not letting it (HIV) take over. And that means having to think of yourself as a priority, allowing yourself to do what you want, because you're not sure you're going to be able to postpone it.'

The feeling of loss of control is common amongst antibody positive people because HIV is untreatable and unpredictable, and

many of the therapies practised by infected people are aimed at regaining this control. 'Control of my life, which includes freedom of choice, is vital. After my diagnosis, I felt that everything had been taken away. I had no control, the virus would kill me. It's taken six years of building up this control', observes Terry Morgan, HIV+, who uses Shiatsu and creative visualisation to cope psychologically with his illness.

Given the importance for a sero-positive person of regaining and retaining control, and the nature of HIV as a lifelong but not necessarily terminal disease, we looked at the types of diseases treated by shamans in communities where traditional healers and scientific medicine coexist. Kleinman and Sung, researching Taiwanese cultures, identified indigenous practitioners as largely treating 'non-lifethreatening disorders in which management of the illness is a larger component of clinical management than biomedical treatment'. Chavunduka, reporting on shaman healing among the Shona in Zimbabwe, says that shamanistic medicine is used 'to achieve almost any end that requires for its success control'. He says too that chronic non-incapacitating illnesses are treated by shamans, while patients with diseases such as pneumonia will consult a doctor. Terry agrees: 'I think both types should be available.' Many people with HIV use complementary therapies on a day to day basis and consult a scientific doctor for opportunistic infections. Terry's consultant knows that he uses both scientific and complementary therapies, and this system of using the two types of care available is becoming so common amongst people with HIV and AIDS that many treatment centres for HIV-related conditions, such as the Kobold Centre in London, now offer their clients access to both types of treatment on the National Health Service.

Shamanic societies are more interested in why someone is ill than in how the person got that way. In the AIDS field many therapists are looking at preventive techniques and are accepting the existence of co-factors alongside the main routes of transmission as a reason why, among those exposed to HIV, some people contract the virus and some do not. Dr Laurence Badgley defines a co-factor as something which 'influences the health and makes it possible for the disease to occur'. For the development of Arc or AIDS, Badgley (and others) accept a number of co-factors, including alcohol, drugs (some prescribed, some illicit, and very definitely nicotine), poor diet and stress. Ikuko Osumi, a shamanic practitioner of Seiku-jitsu, talking of a patient with liver cancer, attributes his disease to remarkably similar factors. 'He is a man who has been through periods of extreme anxiety and worry . . . The poor condition of his liver created his skin disease. The ointments he has been using were absorbed by his skin and passed into his blood . . . Because his digestive system wasn't working properly, he wasn't getting proper nourishment from his food. Even if he had only worked every other day and on the days off stayed at home to have a long relaxed breakfast and talked to his wife, he would have produced more saliva and the hormones that produce proper digestion. That kind of relaxed life would have saved him from becoming seriously ill.'

Another cause of disease from the shamanic perspective is that of taboo violation. In *The Shaman*, Rogers notes for example that 'Taboo violation is a common cause of sickness among many North American Indian people. The Eskimo of Baffin Land believe that a dark cloud of vapour, invisible to ordinary men, gathers around a violator of taboo. This attaches itself to his soul and makes him sick.' Many shamanic societies accept that the physiological symptoms displayed by the offender may be related to guilt at the breaking of the taboo, even where an apparent physical cause exists. Among the Azande people, for example, Rogers says 'a scald on the hand is understood to be the result of hot water burning the skin. Yet the act of scalding, they feel, is brought about by the magic of a malicious enemy . . . Such reasoning also occurs in today's western culture. A person who suffers from an illness may feel that his malady is a visitation for his sins, although it has a scientific, clinical description.'

This kind of reasoning may well apply to people with HIV. In most western cultures, homosexuality is still considered a sin or amoral violation, as is intravenous drug use — or abuse, at it is frequently, and tellingly, called. If someone believes that they have contracted the virus through either of these routes, and if they accept even partially the value judgements of their society, they may find that the physical and psychological problems associated with an ab+ diagnosis are compounded by guilt. Even those who have contracted the virus through routes to which society does not attach a stigma, such as blood transfusion for haemophilia, may feel guilty about the pain they have caused their families and friends, or because they fear they may have passed the virus on.

Some indication of just how much of a role guilt, fear and anxiety play in relation to HIV infection is shown by the World Health Organisation estimate that the ratio of undiagnosed to diagnosed cases of HIV is 10: 1, and that the majority of those who are not aware of their antibody status remain asymptomatic. The negative feelings of people with AIDS and HIV are reinforced by media attitudes. The media has consistently portrayed some cases of the virus as 'deserved', separating antibody positive people into 'guilty' or 'innocent' victims ('victim' itself is an emotive word), and has perpetuated the myth of high-risk groups, rather than high-risk behaviour. Such attitudes have been quickly adopted by many people and, combined with a more natural fear of becoming infected through social contact, have helped to ensure that people with AIDS and HIV are frequently afraid of other people's reactions to them; and may also be afraid of the virus itself, because the only information they have about HIV comes from the highly sensationalised accounts in the press. Antibody positive people, however much they may know they have done nothing to deserve their infection, may have trouble in believing this, faced with so much media and public emphasis on their supposed guilt.

Rogers believes that this concept of conflict between ego and superego is recognised in the shamanic model of illness: 'This involves the failure to distinguish factors derived from the ego, that part of the personality which perceives, governs

thought and adapts reality, from those derived from the superego, which embodies culturally acquired moral and ethical elements, and which instigates self-criticism and self-punishment. Such conflict and confusion . . . may well result in various kinds of disturbance, affecting the health and behaviour of the individual. The patient may feel that his dereliction is responsible not only for his own ill-health, but for the sickness and misfortunes of others and that he has endangered the welfare of the entire community . . . The therapy of shamanistic treatment can aid through persuasion and catharsis, quieting the superego impact, lessening the conflict between a rigid and exacting moral code and a realistic pattern of behaviour.' Much of the work of HIV counsellors and therapists is aimed at helping ab+ people to resolve this type of conflict, and to accept that their lifestyle, however deviant from social norms, does not mean that they deserve to be ill, or that they necessarily present a risk to others.

Social factors are accepted as causing disease in shamanic cultures and many of the techniques practised by shamans are about reintegrating people into society. Chavunduka defines disease as a medical entity, illness as a social entity or status, and believes that sickness is a manifestation of individuals' feelings and the reactions of others towards them. Similarly Kleinman and Sung: 'Let us call disease any primary malfunctioning in biological and psychological processes. And let us call illness the secondary psychosocial and cultural response to disease, e.g. how the patient, his family and social network react to his disease.' For many people with HIV and AIDS the only reactions they expect (and, all too often, encounter) are negative ones, and coping with prejudice, misinformation and ignorance can be a source of immense stress and apparent physical illness. Terry Morgan says: 'It was six months before I could talk to my friends because of the stigma, and I don't think that has changed for most of the people, and it leads to immense stress. I found it very difficult, not only thinking that next time I get a cough or cold I'm going to die. I believe that some of my early illnesses were stress related, and I'd recognise this now, but not then. Then each symptom was the beginning of the end, which created more stress and then more illness, but I wasn't aware of this and blamed it all on HIV.'

This kind of stress, isolation and depression can lead to physiological sensations, often including lack of energy, loss of appetite and sleep disturbances. These symptoms are commonly regarded by the medical profession as purely physiological — 'When I went back to the clinic to find out why I was losing weight, they said, "You're bound to — you've got HIV"' — although by sero-positive people they are often recognised as an emotional reaction. 'I was so devastated when I was diagnosed that it led to all sorts of physical symptoms, pains, dizzy spells, fainting fits . . . I was so frightened — of my emotional state as well as my physical one.' Kiev believes shamans accept that 'to rehabilitate [the patient or client] the physician must not only treat his body, but inspire his hopes, mobilise his environment on his behalf and actively help him to resume a useful place in society'. For antibody positive people, this process may involve a re-

evaluation of what is useful, of one's goals, ambitions and expectations, often in conjunction with counselling or self-help 'body-positive' groups. One HIV+ man known to one of us changed his job from accountancy, which he had always hated but which was 'safe' and would provide security for his old age, to working for a charity which provides support for people with AIDS and HIV. He is currently touring the world on an overdraft — an idea which is probably abhorrent to most accountants! Many sero-positive people work as volunteers in an AIDS-related field, because by doing so they meet people who will not condemn them for their antibody status, and who do not have negative ideas about the lifestyle people with HIV and AIDS may have led, or be leading. Jacqueline Hockings, a social worker with the Terence Higgins Trust believes that 'social support is another significant factor. If you are accepted by those around you, feelings of self-worth are confirmed and encouraged. If you feel rejected by others, you are likely to feel little self-worth and value as a human being.'

Most shamanic cultures recognise the role of society in treating, as well as contributing to the cause of, disease. Among Navaho Indians, therapy also involves group participation. 'The patient is not left alone; his restoration to health is a community project. The people in the community assure him that they wish him well and want him to assume his place in the affairs of their society. As an individual he is important to their group.' The importance of this biopsychosocial interrelationship has not yet been incorporated into treatments offered by the scientific medical profession, but many complementary therapies operate on the group support theory, for example the Terence Higgins Trust's AIDS Mastery weekends.

## *Therapies: Shamanic and Western*

If HIV does fit the shamanic model of illness, one would expect to find similarities in the therapies used by both groups.

Because shamans treat people, not diseases, they are prepared to devote a great deal of time to their clients, discussing not just their illnesses, but also their role in society, their relationships with their family and peer group and their feelings about these issues, in much the same way as counsellors do with those who are antibody positive.

Shamanic treatment usually takes place over a number of sessions, as does HIV counselling, and a part of the session usually involves the interrogation of the client, wrapped up in the rituals of particular culture. Rogers reports that: 'The Mayas of Chiapas, Mexico, use a form of diagnosis through pulsing . . . a dialogue is believed to take place between the patient's blood and the healer's thumb placed on the patient's pulse. During this the patient reveals his fears . . . interrogation as a part of the diagnostic process is part of the doctor's effort to obtain all of the data which he feels are needed to pinpoint the probable cause of the illness.' More than a diagnostic aid, this apparent sympathy and even empathy on the part of the shaman helps the patients by making them feel that with someone so powerful on their side they cannot fail. Western doctors, on the other hand, are usually much less concerned with their

patients' emotional state, and are frequently too busy to be able to listen to their clients' problems in depth. 'The other thing I find difficult is that doctors don't have time to talk to you . . . and they don't take into account what the patient really wants . . . I think it's because they don't want to get involved emotionally.' (John, aged 33). It seems likely that doctors could actually cut the number of times their patients visited, however, by listening for longer in the first place. Terry: 'Doctors taking the time to listen to you can halve the stress level, make you see there is a light at the end of the tunnel, give you a goal to work toward.'

In shamanic treatments the client is expected to take an active role, and this in itself may be part of the therapy. Murphy suggests that the importance of involving the patient, especially in acts of atonement, is that it allows him to believe he is rid of the cause of the disease. This client participation is also present in the complementary techniques used by people with HIV. Jacqueline Hockings notes, 'Complementary therapies usually involve the participation of the person who is being treated and as such are a positive factor in allowing the individual to regain . . . a relationship with their body.'

Many of the complementary therapies used by people with HIV share a basic belief with shamanic cultures, that energy is transmitted by life force. It is accepted that the life force of humans is part of the life force of the universe and that energy may be drawn from one source and transmitted to another. In a case quoted by Osumi, 'There are other times when she does not give Seiki directly through her own body but attracts it from the immediate surrounding atmosphere.' Terry Morgan says 'individuals can tap into the energy which is around them, keep as much as they need and direct the rest to others'. Although Osumi and Terry are talking about two different kinds of therapy (Seiku-jitsu and a form of visualisation which Terry uses), the principle underlying them is obviously the same. Both accept the need to be in a state of altered consciousness before beginning the therapy, which Osumi calls a state of 'no-thought' and Terry describes as 'having an empty mind'. These similarities in the therapies reflect a common view of the nature of illness. Osumi says: 'Our tendency is always to see illness as a weakness, as something that must be hidden or fought or conquered, instead of something to be entered into in a positive relationship, so that the potential strength and wisdom that are held within it are revealed.' Terry concurs: 'Complementary therapy isn't a cure, it's a way of tapping into self-awareness and learning to live a better quality of life. I'd rather have ten years of quality life than thirty years of plain ordinary one.' Therapies are a move towards improving the quality of life; they seek to make a person's life better, which may not necessarily involve a cure of their illness. 'Having been given Seiki does not mean that there is suddenly a miraculous change in our state of being . . . The need for discipline and commitment is essential in this respect . . . by developing our Seiki . . . we become our 'real selves', growing to our full potential as human beings and at the same time extending the span of our lives.' While Jim (diagnosed AIDS) says: 'I haven't always been as positive as I am now . . . I started off with a seed, I have

now got a tree. And we all know how long an oak tree can live.' To Osumi, Terry and Jim, the illness and the therapy provide an opportunity to discover something about themselves, to improve their lives in some way; any lengthening of life is secondary.

The shamanic model of illness compares well with that of the western complementary medical view of HIV as chronic, but non-incapacitating. Both models require management and control more than drug based remedies. In shamanic cultures today, certain diseases may be referred to western practitioners and the symptoms present in an Arc and AIDS diagnosis may respond to drugs. However, this does not remove the underlying cause. Here too, HIV and shamanic models have much in common, both accepting the existence of a deeper underlying cause for the original illness — stress, diet, anxiety, taboo or moral violation. Both accept the role of society in exacerbating and treating disease, both accept the need for faith in the therapist and both refute the western dichotomy between somatic and psychological disease. There are differences in the actual therapeutic techniques used by shamans and by the therapists, doctors, counsellors and social workers who have taken over the shamanic role in the treatment of HIV — complementary medicine does not use the ritualistic elements of shamanism — but the objective remains the same.

In dealing with the challenge of HIV treatments, we in the West are turning increasingly to 'complementary' models of health care. The shamanic framework of humanistic medicine confirms the structure of the new therapies as consistent with an ancient tradition. In many cases, western practices which have been developed ad hoc can be seen to be part of a more comprehensive, coherent healing strategy, a shamanic perspective that may help to integrate and focus some of the HIV treatment now current, guiding us to areas in which we might yet develop better ways of understanding the psychological approach to this devastating illness.

## *Further Reading*


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