The Adoption of Shamanic Healing into the Biomedical Health Care System in the United States

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THE ADOPTION OF SHAMANIC HEALING INTO THE BIOMEDICAL HEALTH CARE SYSTEM IN THE UNITED STATES

A Dissertation Presented

by

LORI L. THAYER

Submitted to the Graduate School of the University of Massachusetts Amherst in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2009

Anthropology
THE ADOPTION OF SHAMANIC HEALING
INTO THE BIOMEDICAL HEALTH CARE SYSTEM
IN THE UNITED STATES

A Dissertation Presented

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very, very generously taking the time to support mine. David Samuels also graciously provided support in his knowledge of ethnographic research. And if not for my outside committee member, Cecile Carson, MD, this project never would have materialized.

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ABSTRACT

THE ADOPTION OF SHAMANIC HEALING INTO THE BIOMEDICAL HEALTH CARE SYSTEM IN THE UNITED STATES

MAY 2009

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Following cultural anthropological inquiry, this dissertation examines the adoption of shamanic healing techniques into Western medicine and the resultant hybrid modality of health care fostered by two disparate healing traditions.

As the U.S. populace increasingly turns to alternative forms of healing in conjunction with, or in lieu of, conventional Western medicine, shamanic healing has been added to the list of recognized non-conventional therapies. Shamanism, once prevalent throughout most of the world in various cultural forms, is purported to be the oldest healing modality, dating back to the Upper Paleolithic in Siberia. Historical excoriation and extermination from religious and political dogma have plagued shamanic cultures for centuries while their healing practices have been rebuked by Western concepts emergent from the Scientific Revolution—whereupon the Cartesian Split and a corporeal view of the body transformed the field of medicine.

In the United States, over the last decade, a new and growing subculture of health care practitioners, including “Western” educated medical practitioners, is seeking out shamanic training for personal and professional development. This study examines how
the adoption of a healing paradigm borne out of indigenous cultures oriented toward communal living and local economies is adapted to a Western culture steeped in individualism, commercialization, and commodification. Through surveys, interviews, and ethnographic research, the investigator provides numerous examples and analysis of the practice of shamanic healing techniques in medical clinics, health care centers, and hospitals. In particular, this study will focus on the shamanic training of health care practitioners, their motivations, the manner in which they incorporate shamanic healing techniques into their treatment protocols, as well as patient/colleague/administrative responses and institutional barriers.

A comparative analysis provides discussion on both the metamorphosis of shamanic healing traditions appropriated within a biomedical framework as well as the influence of spiritually-based healing practices upon the established medical culture in the United States today. Through the lens of highlighted individual experiences, the investigator offers insight into an emerging hybrid healing modality embedded in cultural contrasts that also serves as a catalyst for the renegotiation of the meaning of healing.
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CHAPTER 1

SHAMANISM, MEDICINE, AND CULTURE: AN OVERVIEW

Introduction

This dissertation presents a contemporary study of the adoption and adaptation of shamanic healing traditions practiced in collaboration with Western health care services in the United States. Biomedicine, now the dominant system of health care in the United States and globally, emphasizes technology, surgery, and pharmaceuticals and focuses primarily on human physiology, reducing disease to biology, while ignoring other factors such as social structure and environmental conditions (Baer et al. 2003:11–14). In contrast, the religio–spiritual practice of shamanism entails an acknowledgement of the spirit world that informs diagnosis and healing with the ultimate goal of achieving an energetic balance between the individual and his or her social and natural environment.

As greater numbers of Americans seek out alternative and complementary forms of healing, examining this growing phenomenon provides a window into changing Western notions of the body, health, healing, and the environment. An anthropological approach provides a unique perspective in the examination of ongoing cultural shifts that are manifested, in part, through changes in health care. Expressed interest in non-allopathic forms of healing, especially indigenous-based systems of healing, provides a rich and contrasting framework of comparative analysis to investigate both why and how the cultural transfer of a holistic healing system is occurring; and its cultural impacts within the United States as well as upon indigenous source groups. In particular, the subfield of Critical Medical Anthropology (CMA) defines health as “access to and control over the basic material and nonmaterial resources that sustain and promote life at
a high level of satisfaction” and more importantly advocates that “health is not some absolute state of being, but an elastic concept that must be evaluated in a larger sociocultural context” (Baer et al. 2003:5). This study includes exploration of the “elasticity” of notions of health in the United States when an alternative form of healing is practiced in combination with biomedicine.

Furthermore, the groundswell of interest in alternative health care most likely reflects considerations beyond the organic realm. Basic tenets of traditional shamanism address the emotional and spiritual health of an individual as well as physical stature; and more importantly, the relationship between individual, community, and planetary health. However, it also needs to be recognized that the reasons of attraction to a healing system provide more insight into a culture than the defined qualities of the system itself, i.e. the latter may not necessarily be a reflection of the former. Ultimately, in the exploration of the ministering of shamanic healing in collaboration with Western medicine, this study seeks to answer two overriding questions: (1) How does Western culture reconfigure the traditional practice of shamanic healing?; and (2) How does the adoption of shamanic healing, and its underlying tenets, influence the practice of Western medicine in the United States?

**Background**

As the U.S. populace increasingly turns to alternative forms of healing in conjunction with, or in lieu of, conventional Western medicine, shamanic healing (though less well-known than many other alternative modalities) appears to be gaining in popularity. Shamanism is purported to be the oldest healing modality, dating back to the Upper Paleolithic in Siberia (cited original dates vary in thousands of years), and has
been practiced in various cultural forms throughout most of the world. However, the healing paradigm of shamanism has been rebuked by the Western world for hundreds of years due to opposing belief systems of monotheism and reductionist science, when more corporeal views of the body took hold in the field of medicine. Yet Westerners are now more openly turning to indigenous practices of healing and ritual in response to dissatisfaction with the biomedical model, sometimes in complete abandonment of Western medicine, but more often in a complementary fashion.

Researchers have studied syncretic or hybrid forms of healing using different cultural traditions of folkloric healing (e.g. the practice of *vegetalismo* in Peru or mestizo ayahuasqueros in Amazonia (Bodeker 1999:277; Narby 1998:60), as well as hybrid forms of ethnomedicine practiced in combination with biomedicine in indigenous cultures (Finerman 1989; Greene 1998; Heckler 2007; Janes 1995; Langwick 2008; McGrath 1999; and Rekdal 1999). Yet it is only recently that researchers have begun to look at the adoption and adaptation of traditional healing practices in the United States. Some argue that this is another form of cultural exploitation by the dominant culture, or that the transfer of indigenous healing is not possible when removed from its localized cultural context. These concerns are discussed in depth in chapter 8. But the reality is that Westerners are appropriating shamanic practices in one manner or another and a cultural phenomenon, often referred to as “neo-shamanism,” is taking place. This is reflected in part through a cultural shift in the health care system of the United States. In an age of advanced medical technology, many people are seeking out an age-old nature-based healing modality; and thus, this aspect of the movement in itself is worthy of study.
Although social scientists more recently have begun to examine the inclusion of various non-conventional therapies in the health care system of the United States, few studies have yet to examine the specific adoption of shamanic healing into Western medicine. [Note: Existing studies have focused more on the use of shamanic healing in psychotherapy settings and in the treatment of Native Americans and immigrant subpopulations in institutionalized settings.] Even lists of alternative medicine and therapies (e.g. nauropathy, homeopathy, osteopathy, herbalism, chiropractic, acupuncture, healing touch, reiki, massage, and hypnosis) tend not to include shamanism. While many of these practices still lack credibility within the American Medical Association, and thus legal standing in some states, shamanism is one of the most dubious and obscure healing protocols of all the other non-conventional therapies. As Western trained doctors, nurses, and other professional health care providers study and adopt shamanic healing techniques into their protocols, shamanic healing may be entering a breakthrough stage of acceptability by the status quo—albeit in very small doses.

**Alternative Medicine in the United States**

Though Micozzi (2001) notes that allopathic medicine is only one of many options of health care, most authors reference treatments outside of the Western biomedical model to be “alternative” or “complementary,” (jointly referred to as “CAM”). The National Institutes of Health National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as “a group of diverse medical and health

---

1 A cutting edge book written for physicians (Essentials of Complementary and Alternative Medicine 1999 edited by Wayne B. Jonas and Jeffrey S. Levin) includes twenty chapters on different complementary and alternative medicine systems, yet shamanism is not included among them.
care systems, practices, and products that are not presently considered to be part of conventional medicine.\(^2\) It further states that “what is to be considered CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional health care.” NCCAM defines conventional medicine as “medicine that is practiced by holders of MD (medical doctor) or DO (doctor of osteopathic medicine) degrees and by their allied health professionals, such as physical therapists, psychologists, and registered nurses” (http://nccam.nih.gov/health/whatiscam/overview.htm). Although sometimes biomedicine or Western medicine is referred to as “traditional,” for clarity, this study denotes Western medicine as “conventional” (signifying that which is the norm in the United States to date) and indigenous healing systems as “traditional.”

Eisenberg et al. (1993) conducted a national survey in 1990, determining that the use of unconventional therapy in the United States was much greater than previously reported. Extrapolation of their results showed that one out of three Americans used unconventional therapy; that more visits were made to unconventional therapy providers than to U.S. primary care physicians; and that three-quarters of the associated costs of unconventional care was paid for out-of-pocket; an amount comparable to what Americans spent out-of-pocket for all hospitalizations. It has also been determined that patients usually opt for a complement of biomedical and unconventional treatment, and often seek unconventional treatment as a form of health promotion rather than in

\(^2\) NCCAM separates CAM into four domains: Mind-Body Medicine, Biologically-Based Practices, Manipulative and Body-Based Practices, and Energy Medicine; and also recognizes Whole Medical Systems that cut across all domains. Such systems include homeopathy, naturopathy, Chinese medicine, and Ayurveda (http://nccam.nih.gov/health/whatiscam/overview.htm).

Many authors have noted various reasons for people’s preference for CAM, such as its enhancement of personal agency, its patient-centered rather than practitioner-centered approach, its use of natural remedies, its focus on health restoration rather than treatment of end-stage pathology, its attempt to reverse underlying causes of ill-health rather than just symptom relief, its noninvasive approach, its lower cost (though minimally covered under health insurance policies), its attendance to a mind–body–spirit connection, and its inclusion of different spiritual approaches (Micozzi 2002; Pizzorno 2002). Mueller et al. (2001) found that religious involvement and spirituality are associated with better health outcomes, and yet these issues are rarely addressed in the context of physician care or included as variables in medical research. Furthermore, while notions of illness and healing are embedded in belief systems, Sociologist Meredith McGuire (2002) argues that the “meaning” of illness, pain, etc. is generally not addressed by the dominant medical system. In contrast, many non-Western cultures question the metaphysical, rather than organic, causality of illness and injury. These indigenous cultures believe that there is a message inlaid with the dysfunction, and until the patient “hears” that message, healing cannot take place (Bruce 2002:129).

Studies have shown that over the last two decades, medical students and young doctors have requested more training in alternative therapies (Reilly 2002) and medical schools in the United States and the European Union have acceded (Baer 2002; Barberis et al. 2001; Thomas and Bright 2002:85). In the United States, over the last decade, a
new and growing subculture of health care practitioners, including “Western” or biomedically-trained medical doctors, is seeking out training to practice shamanic healing techniques (often via U.S.-based organizations with directives to teach and preserve shamanic healing practices). Yet even with the extensive reporting of a broad-based appeal for alternative healing modalities within the United States, a critical medical anthropologist warns “it is important not to overlook the capacity of biomedicine and its patrons in the capitalist class and the state sector to co-opt [these alternative modalities]” (Baer et al. 2003:41).

**Culture and Environment: Modernity and Health**

There is much discussion by theorists regarding key differences between the Western biomedical model and indigenous/traditional healing systems. Dating back to the period of Enlightenment when modern science took shape, René Descartes’ theory of the mind–body separation (*Discourse on the Method* 1637), referred to as the “Cartesian Split,” founded a new direction in the medical view of the body. The Western scientific model tends to be reductionist and particularistic (i.e. directed at a specific disease) while indigenous healing offers a more holistic perspective (looking at the whole person) (Young 1996:110). A reductionist approach to biomedicine continues with a centralist goal of mastering “the minutia while missing the whole.” And “it is the whole,” writes MD Marc Micozzi in his introduction to a text on complementary and alternative medicine, “that people are missing in modern medicine” (2001:xiii). In contrast, indigenous and Eastern systems of healing address the bioenergetics of a body–mind–spirit connection, working with something akin to a “life-force” of each living being. Because the design and procurement of health care is steeped in sociocultural
interpretation (Cassidy 2001), adoption of shamanic practices seemingly requires an accompanying ideological shift that may be more difficult to establish in a Western culture.

While the biomedical model excludes recognition of the human–environment connection in health maintenance, this precept is a foundation of most traditional systems of healing. “Many alternative health systems define health and healing in ways that dramatically reduce distinctions between the health of individuals and the health of their environment. As a result, many such systems value environmental conservation and connect the healing of humans with the healing of the world in which they live” (Hufford and Chilton 1996:59). Many fields of study explore differing cultural perspectives of the human–nature relationship with researchers attempting to reevaluate both extreme images bestowed upon indigenous peoples—from the hostile primitive savage of the colonial era to the Rousseauian “noble savage,”—in an effort to add nuance to the either/or classification. Anthropologist Gerardo Reichel-Dolmatoff concluded from his work with the Tukano Indians of Columbia that the Tukano’s relationship with nature is not hierarchical, in which they have mastery over their environment, nor one that would be described as “in harmony with nature.” Because nature is not seen as a separate physical entity, the Tukano view themselves as an integral part of nature. Therefore, it is not possible to confront, oppose, or commune with it (Reichel-Dolmatoff 1976:11). Rather, nature is a part of one’s very beingness.

Author John Perkins writes in one of his accounts on shamanism that a Shuar shaman stated: “There’s nothing more important than for people to shapeshift into nature. We must feel our hearts as the same hearts as those of the anaconda, the jaguar, the river,
and the chonta tree. We must also feel our souls as the same, and our bodies as well.

This is the spirit of oneness“ (Perkins and Chumpi 2001:56–57). A member of the Okanagan community, Jeannette Armstrong writes about her culture’s definition of self, noting that the Okanagan word for body “literally means ‘the land–dreaming capacity’” (Armstrong 1996:463). Oren Lyons of the Onondaga Nation of New York explains that ‘biodiversity’ really means ‘all our relations’, a phrase with which the Lakota end all of their prayers (Golliher 1999:448–450). Thus common images of nature in indigenous cultures portray humans as integral to nature. And thus the health of humans and the natural world are intricately linked.

UNEP (United Nations Environment Programme) recently published a synthesized volume of essays entitled *Cultural and Spiritual Values of Biodiversity* 1999 in which numerous authors discuss the “‘inextricable link’ between biological and cultural diversity” (Posey 1999:3). A prevailing theme throughout these essays advocates for an acknowledgement of indigenous knowledge (and peoples) as a means of addressing the “global environmental crisis [that] cannot be solved by technological tampering (‘quick fixes’) or superficial political measures” (Posey 1999:15). One might argue that the health or well-being of the planet is dependent on this inextricable link between biological and cultural diversity; and that in turn there is a bilateral relationship between the health of the planet and the health of the individual. Indigenous peoples often view themselves as “guardians and stewards of nature” (Posey 1999:4–5) and shamans in particular play a key role in maintaining the balance between the health of the individual, their tribal community, and the environment. That a Kayapo chief from Brazil expresses the wish to return “the knowledge that the forests and this planet are
alive” to those “who have lost the understanding” (Posey 1999:16) raises the question of how and whether this understanding can be transferred from traditional societies to the dominant culture – a culture that commonly reveres nature more for its utilitarian value.

Without essentializing or over-romanticizing individual behavior of indigenous peoples, there may be value in noting this ideology within the context of a cultural overlay. This is not the mainstream cultural message commonly propounded by the techno-industrialized United States. Though a contributor to UNEP report states that the marginalization of indigenous knowledge has shifted into reverse since the 1960s, much of this is due to romantic notions as well as practical (i.e. commercial) motivations (Slikkerveer 1999:183).

Contemporary theoretical anthropology eschews the essentializing of indigenous peoples as “noble” or “savage.” A number of researchers have conducted qualitative as well as quantitative analyses of resource management by indigenous groups, arguing both for and against the existence of any inherent system of “genuine conservation” (as opposed to “epiphenomenal conservation”)

3 (Alvard 1993; Hunn et al. 2003; Ruttan 1998; Smith and Wishnie 2000). While such a debate extends beyond the scope of this research, one of the stated roles of a shaman is the maintenance of some semblance of balance between human existence, the environment, and the spirit world, via the principle of reciprocity (Furst 1994:2). Contempory anthropology has long since abandoned the

3 Conservation behavior is a matter of short-term costs as well as outcome. Genuine conservation is when individuals make sacrifices or incur short-term costs for long-term gain. Epiphenomenal conservation does not involve direct costs. The only “costs” are those of opportunities not taken. Thus a small band or group of individuals may appear to be practicing genuine conservation based on the observed surrounding resources, when in fact it may be a result of epiphenomenal conservation (Alvard 1993:358 and Hunn 1982:21).
first theoretical postulations of cultural evolution in which Lewis Henry Morgan’s theory of stagism (1877) proposed a hierarchy of cultural developmentalism. However, the notion of unilineal cultural evolution persists in political arenas that foster economic progress and development as the earmark of “advancement.” Nation–state economies are most readily evaluated on their GDP (Gross Domestic Product) that measures resource extraction and consumption, even when associated with a lower quality of life. Contrary to this notion of cultural advancement through technological and economic achievement, Anthropologist Marc Micozzi, MD refers to a “reverse technology transfer” occurring due to the integration of “therapeutic approaches associated with the ancient health traditions of India and China (as well as the indigenous peoples of the Americas)” into medical practices in the United States (Micozzi 2002:400).

If we can expand our definition of “progress” to include nontechnical, nonmaterial advancement, Western societies may gain a realization that indigenous cultures are no more static than “First World” cultures – innovation and agency persist in both. A Shuar healer is quoted while speaking to an American, “Every generation of Shuar since the time of Tuntiak in the beginning has progressed. We’ve cultivated forest plants, learned new ways to fish and hunt, adapted to floods and droughts; our shamans are constantly understanding new things about healing, journeying, and employing the power of the herbs” (Perkins and Chumpi 2001:155). Environmentalists such as Donella Meadows have long advocated that the industrial world shift from an ideology of measured growth based on increased production of material goods to one of qualitative development (Meadows et al. 1997).
Micozzi also notes that while the biomedical community is attempting to evaluate the measurable efficacy of alternative forms of healing in the conceptual paradigm by which Westerners understand, explain, and interpret human health, “there is a parallel shift occurring in a broader context” which he refers to as an “ecology of health.” He adds that the field of anthropology and other social sciences may be key in “understanding the limitations of the present biomedical model” through the study of cross-cultural medical perspectives (2002:398). Other health care practitioners and academics have also advocated greater attention to environmental aspects of medicine (Bright 2002; Chesworth 1996; Irvine and Warber 2002). A conference entitled “The Greening of Medicine” was held in San Rafael, California in October, 2002, sponsored by a group calling themselves “Bioneers.” In a comparable “greening of religions” movement, there has been a reciprocal call for scientists and environmentalists to acknowledge the role of the human spirit in understanding the workings and maintenance of natural systems (Gardner 2002; Gollther 1999).

Many scientists continue to analyze the essence of human existence through the isolation and investigation of the body’s most basic parts, e.g. the Human Genome Project and Human Genome Diversity Project, celebrated by the recent completion of the mapping of the human genome in its entirety. Human development, physiology, and behavior can often now be linked to the function of identified genes. And yet research into the understanding of gene expression now shows the ever greater importance of the environment in genetic expression (Lewontin 2000; Rossi 2002). Ernest Lawrence Rossi outlines the relationship between healing and gene expression, using the “Gaia–gene–body–mind complex adaptive system” as a model of how aspects of the environment
affect the body down to the genetic level and vice versa. Thus even within the field of genomics, some researchers may be shifting their view of genes as building blocks to genes with extensive pliable expressivity. The shaman’s purported ability to shapeshift, i.e. transform into another being (e.g. a bat or a jaguar), might be the ultimate example of genetic plasticity!

If we accept the premise that indigenous knowledge may offer invaluable wisdom to address environmental concerns, and that there are critical environmental conditions gravely affecting human health (as well as other biota)—take for example global climate change—we need to investigate possible mechanisms of transfer of knowledge and ideology from indigenous peoples to the dominant culture. One means of exploration is to examine Western medicine’s adoption of shamanic healing techniques.

**Shamanism**

Throughout the literature on shamanism, its origins are noted to have emerged in Siberia and Central Asia; the word “shaman” comes from the Tungusic *saman*. However, the broader reference to shamans/shamanism is greatly debated in terms of its meaning and appropriate usage. Many anthropologists, in particular, consider this terminology to be a social construct, a Western category with only vague meanings of overgeneralization (Atkinson 1992; Kehoe 1996; Klein et al. 2002; Krippner 2002). Most anthropological studies are “ethnographic and focused on single cultural traditions” contextualizing shamanic practices in the local (Atkinson 1992:308). Yet many disciplines and texts use these terms to denote a varying range of categories of magico–

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religious practice, from the plains of Siberia, to non-Western religions featuring ecstatic states, to contemporary practices of healing and self-expression (Kehoe 1996). Even within the field of anthropology, many researchers use the terms “shaman” and “shamanism” to refer to a defined role (e.g. one who accesses altered states of reality) and a practice with a set of defined functions (e.g. contacting spirits and supernatural entities, healing the sick, and controlling the weather) rather than a particularity within a single cultural context (Lewis-Williams 2003:167; Whitley and Keyser 2003:387). A more detailed discussion of the historical use of these terms will be presented in chapter 3.

The universality of shamanism has also been argued from a universal human neurological function as well as an evolutionary biological perspective: that the ability to access shamanic-like hypnotic trance states is genetically selected for in many population groups (McClenon 1997). Issues such as the usage of the term and universality of shamans will be discussed in greater detail in chapter 8. For purposes of this study, the terms “shaman” and “shamanism” will refer to individuals and a set of practices across the globe; however, the term “shamanic practitioner” and “neo-shamanism” will be used when referring to the recent adoption of traditional shamanism by Westerners.

Interpretation of the shaman’s role has also shifted historically. Prior to the mid-1900s, social scientists interpreted shamans as demons, charlatans, schizophrenics, psychotics, epileptics, and deviant; but by the mid-century, the academic understanding shifted to appreciate the shaman’s role as one of creating order or reestablishing balance (Atkinson 1992; Eliade 1964; Narby 1998). The shaman serves as an intermediary between the human community, the larger ecological field, and the spirit world,
interpreting an individual’s illness as a “loss of soul”\(^5\) and/or a consequence of an upset in the ecological balance. Thus the healing shaman’s role is to restore a systematic balance to the inner environment of his client as well as the outer environment that includes the human community and surrounding environs (Abram 1996; Bodeker 1999; Eliade 1964; Reichel-Dolmatoff 1976). A Yachak shaman, Esteban Tamayo, explains that a shamanic diagnosis involves “sensing the spirit of the person through intuitive means” based on the assumption “that all disease has a spiritual basis.” Only after “invoking the help of the spirit world [and] traveling to the spiritual realm to effect change” is attention given to the needs of the “physical, emotional, and mental bodies” (Bruce 2002:103).

For some practicing shamans, a key source of “information” is the use of hallucinogenic plants such as ayahuasca and datura (Bruce 2002; Eliade 1964; M. Harner 1980; Narby 1998; Perkins and Chumpi 2001). Anthropologist Jeremy Narby (1998) published a book on the shamanic use of hallucinogenic plants in which he hypothesizes that shamans have long understood the building blocks of life that Western scientists refer to as DNA. Shamans have reportedly stated that plant spirits convey messages to them while they are in a trance state; and it was pointed out by a Shuar shaman that it is not the “plant juices” that ethnobotanists are so rapidly attempting to study that is of importance, but the “spirit” of the plant that provides information and healing (Perkins

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\(^5\) The term ‘soul’ has extensive meaning and often depends on the particular religious denomination and/or spiritual orientation. A more generic definition is an understanding that ‘soul’ is “the immortal component, the life and personality force of human beings [and within a shamanistic framework, other living beings as well]– an entity that continues to exist after physical death on a plane of reality separate from the physical world” (Trotter 2001:418). “Soul loss” occurs when a part of the soul flees the body in order to survive a difficult or traumatic experience, either physical or emotional (e.g. sexual abuse, an accident, surgery, death of a loved one, a natural disaster, etc.).
and Chumpi 2001:24). Therefore, attention to indigenous views of and relationships with nature is additionally important in this study because they are integral to the shaman’s healing practice.

**Incorporating Shamanic Healing into Western Medicine**

The manner in which Western health care providers receive training in shamanic healing and how they practice it is a key question in terms of the adaptation of this traditional form of healing. Traditional shamanism is/was practiced by a tribal shaman appointed through inherited lineage or by divine decree in an indigenous culture oriented toward communal living and a subsistence economy (typically hunter–gatherer societies). The shaman-to-be often receives training from an older practicing shaman in the community. Anthropologist Claude Levi-Strauss refers to the “shamanistic complex” made up of the shaman, the sick person, and the participating public (1963a:179).

However, in the United States, most medical practitioners are trained by Western shamanic practitioners (though a small number have trained with indigenous shamans), and more importantly, practice their shamanic healings on individuals in a private setting for a set monetary payment. Thus the communal aspect of shamanic healing is often left out, and a capitalistic component is added in. In most traditional societies, shamanic knowledge is considered sacred, and using such for personal gains is by definition, ‘black magic’ (though small payment in some form is acceptable) (Narby 1998:152). A critical analysis of this and other cultural comparisons will be provided in chapter 7.

There is both the debate as to whether traditional shamans can truly heal, and/or whether Westerners can take on the role of shaman (Johnson 1995:165). Neo-shamanism is emerging in a different setting, a different cultural context than traditionally-deemed
shamanism(s), and thus invariably will present itself in new ways. Yet it is important to move beyond the dichotomy of that which is traditional, primitive (and authentic) versus that which is modern, revised (and unauthentic). To reiterate, the point of this study is to investigate a cultural phenomenon in process and how it manifests in its new hybrid form. As one author notes, “modern social systems in which neo-shamans make their homes is not any kind of essentialist distinction from ‘primitive’ societies, but rather a particular kind of fragmentation and diversity found in such modern societies which have led to an extreme form of self-reflexivity, relativism and subjectivity” (Johnson 1995:173).

How patients adopt shamanic healing into their lives is also of concern. Syncretism and hybridity often involve picking and choosing particular aspects of a practice, whether medical, religious, etc., rather than adopting a practice in its totality. Many Americans often seek out different alternative treatments with relative autonomy to a treatment’s cultural attachments, not necessarily choosing “whole alternative ‘packages’ of healing beliefs and practices, but often a bricolage of alternatives from a wide range of cultural sources” (McGuire 2002:410). Examples include practicing acupuncture while “throwing away its underlying ontological assumptions” or using medicinal plants as drugs outside of their cultural context (Slikkerveer 1999:202). Furthermore, there is debate whether Western interest in shamanism more aptly reflects a reaction to an industrialized, mechanistic society removed from nature; or rather modern concerns of personal health and enlightenment.

The study of the appropriation of shamanic healing techniques into Western medicine raises other aspects of culturally-related issues of modernity and globalization
that transcend the boundaries of health care into general questions of political economy. As we discuss the notion of “the global village,” (resulting in the phenomenon referred to as “time–space–compression”) and tease apart that which is local versus universal, social scientist Doreen Massey (1991) advocates the need to look at the power relations of different social groups from an international perspective. Of course, this is necessary when studying the transfer of indigenous knowledge given that indigenous groups often do not reap just rewards for their sharing of knowledge and resources (resources that in many places are rapidly dwindling). This issue also delves into notions of culturally-bound frameworks of worldviews and cosmology, such as the “hegemony of biomedical definitions of reality in modern Western societies” (McGuire 1988:9) that may be part of the reason for the disparity in power relations in the area of medical treatment and recognition of different healing systems.

Other reasons for the growth in alternative therapy training within the medical establishment is a result of economics, noting that a market niche appeared with individuals who had disposable incomes, willing to pay for alternative treatments out of their own pockets; and that healers who are not professionally trained or who promote self-healing are not accepted by the medical community (Baer 2002; McGuire 2002). As well, there is a need to take into consideration the political economy of CAM in the United States, in terms of who among the U.S. populace has access to alternative treatments that may not be covered under standard health care insurance nor provided by public hospitals.

Finally, there has been a movement within the anthropological community to include political economy perspectives when studying human biology as a means of
“building a new biocultural synthesis” (Thomas 1998). Human adaptation from a human ecology perspective must take into account personal agency when it comes to looking at the interface between human health and the health of the environment. Just as many people in less-developed countries are suffering from living “under conditions of multiple stress with inadequate techno-behavioral means to buffer these constraints” (Thomas 1998:58), it may be argued that many people in high-tech societies are living under conditions of multiple stress as well due to a fast-paced, hypertechnologized environment, and yet do not find adequate healing in the Western biomedical model of treatment for which they have no other choice. One advocate of collaboration between the biomedical model and indigenous healing practices notes that this complement of health care also may benefit indigenous people living in the United States who receive institutionalized medical care. Collaboration will afford them healing services that may be more in line with their cultural background (Young 1996:112).

Reaction to modernity and its accompanying stressors may be one reason driving people to unconventional therapies. But this reaction may also reflect a changing perspective of how some Westerners view the human body, spirit, and “place” within the natural order of our universe. From an anthropological, sociological, (and shamanic) perspective, while “illness in an individual body may be a manifestation of social and political illness,” (McGuire 2002:410), our choice of healing in turn may be a manifestation of shifts in our social and cultural ideologies. How all of this plays out in an individualistic society is of noted interest. Sociologist Meredith McGuire, in her investigation of ritual healing in suburban America (also the title of her published study), found that although respondents “criticized the social sources of illness and illness-
producing behavior (e.g. hazardous or stressful workplaces, advertising that promotes unhealthy behavior, industrial pollution, poverty),” they also typically expressed the belief that health maintenance occurs at the individual, rather than the social, or political, level (1988:249). Religion Historian Paul Johnson critically notes that the system of shamanism taught by Michael Harner’s Foundation for Shamanic Studies (a U.S.-based organization focused on teaching shamanism to Westerners) is a new and distinct form that claims a “universal and non-contingent status” but also “clearly relies on its own proper context, namely that of radical modernity and the discourse of mobility and individual agency” (1995:173). Where does the individual end and the rest of the world begin is a question to be explored within the context of healing. This line of demarcation is more blurred in the shamanic model of health than in the Western biomedical model.

**Indigenous Rights and Cultural Survival**

Although this study will concentrate on the cultural adoption of shamanic healing in the United States, it is also imperative to discuss the impacts of such a movement on the indigenous communities from which this knowledge has been appropriated. The exploitation of natural resources and the enculturation of Western paradigms of religion, education, food production (to name just a few categories) have fostered acts of genocide and ethnocide toward indigenous groups throughout the world for centuries. A growing concern among indigenous groups today is the appropriation of their cultural knowledge. The Scientific Revolution and missionization of indigenous peoples, coupled with modernization and globalization, have greatly contributed to the demise of shamans, their knowledge systems, and their local biota upon which their practices are dependent. Thus the role of the shaman has waned or even disappeared in many indigenous communities.
Western scientists recently have turned their attention to preserving the knowledge of shamans because of their knowledge of medicinal plants—an untapped resource that may hold the clue to many presently incurable diseases. As well, scientists and the public now have a better understanding of the role of the rain forest in global climate conditions; and the fact that indigenous cultures hold a “bank” of invaluable TEK (traditional ecological knowledge). Therefore, there are many self-serving reasons why Westerners have tuned in to shamanic knowledge, including the realization that this resource is a wealth of untapped marketable goods and services. Although the Rio Earth Summit in 1992 produced treaties requiring the “equitable” compensation to indigenous peoples for their TEK, the dominant culture has yet to fully actualize these agreements.

The validity of appropriating a cultural practice can be looked at from a variety of perspectives, and it is the kind of debate that engenders heated side-taking. While science is based on a “universal” set of concepts, indigenous knowledge is “relative and parochial.” Thus there is a “danger [in] turning local knowledge into global knowledge” because it is precisely the local embeddedness of IK [indigenous knowledge] that has made it successful” (Slikkerveer 1999:184). This point directly links into the issue of indigenous rights that will be addressed below.

The appropriation of specific indigenous healing rituals by non-tribal members is considered by some to be a continuation of neocolonialism and ethnocide. Terms such as “cultural imperialism,” “white shamanism,” “plastic medicine men,” and “wannabes” have been coined to refer to New Age ritual practitioners (Bell 1997; Brown 1998; Rose 1992). True efforts to preserve biodiversity, as well as human cultural diversity, may be undermined by what is known as “the hegemony of the commodification process”
There are 300 million indigenous people in the world today who are members of more than 4,000 distinct societies, representing 95% of the world’s human cultural diversity. The disparity between Westerners’ interest in preserving indigenous ecological and medical knowledge to feed their own “material and social impoverishment,” while simultaneously whole cultural groups and their lands are being decimated is of grave concern (Gray 1999:67). Anthropologist Darrell Posey asks, “How can humanity benefit without further undermining the health and well-being of traditional and indigenous peoples?” (Slikkerveer 1999:169). While some indigenous peoples remain guarded about sharing their cultural knowledge and practices, others believe that reaching out to the Western community may be a last resort effort to steer the planet onto a more sustainable path.

Although there are many fascinating accounts of shamanic healings (whether exaggerated or true is up for debate), shamans in many cultures are dying out, as younger members of tribes turn their interest to “modern lifeways.” Harvard-trained ethnobotanist Mark Plotkin (2001) considers shamans to be the most endangered species of the rain forest. Historically, shamans began to fall out of favor at the onset of colonialism when missionaries and incurable Western diseases turned tribal members against their own traditional healers. A Shuar shaman stated that priests had told them that ayahuasca and datura “remove them from reality,” when in fact, they experienced the opposite: ayahuasca enhances a person’s sense of oneness with the world and that “we see the reality in our oneness” (Perkins and Chumpi 2001:57). Another factor in the decline of indigenous shamans is that the initiation and training is quite arduous and requires long
periods of abstinence from food and sex; and the practice itself is considered dangerous (Eliade 1964; M. Harner 1980; Narby 1998; Perkins and Chumpi 2001).

There are organizations that have recently formed, attempting to preserve shamanic knowledge and their related cultural heritage, tribespeople, and homelands. These organizations acquire much of their funding from Westerners interested in exploring and studying shamanic healing via ecotours, conferences, workshops, and arranged private healing sessions. In turn, some of these organizations play a central role in how shamanic practices are transferred and adopted by Westerners. Four key organizations are: (1) The Amazon Conservation Team founded by Mark Plotkin (1995); (2) Dream Change (originally named Dream Change Coalition) founded by John Perkins (early 1990s); (3) The Foundation for Shamanic Studies founded by Michael Harner (1985); and (4) The Center for Spirited Medicine founded by Connie Grauds (2001).

The transfer of shamanic knowledge to the West must include an analysis of the cultural impacts not only on the recipient culture, but on the source communities as well. A Shuar member, Juan Arcos, invited John Perkins, founder of Dream Change [Coalition], to bring Westerners to his village in Ecuador. “Bring people here. . . . Not the ones who think they need to change us, but those who want to learn. Bring them here so they can feel the magic of our rivers and learn from Uwishin, shamans like this old man beside me, about dreaming” (Perkins and Chumpi 2001:11).

Relevance

Clearly, health care in the United States is a pertinent and critical topic of debate, both from an individual as well as societal standpoint. As the demand for more alternative forms of healing rise and health care practitioners gain training in these
alternative modalities, the provision of medical care is metamorphosing. Even health insurance companies are changing their coverage policies to include more alternative treatment. This study provides insight into some of the cultural shifts that are occurring in our society as signified by an increased affinity for shamanic healing, and its connotations by Westerners. What does shamanic healing mean to people in the United States, and why do they want to practice it and/or receive it? More and more Americans appear to be disillusioned with conventional Western medicine, so what does shamanic healing appear to offer up that other health care modalities do not? Furthermore, is shamanic healing strictly an issue of the individual, or does it extend into other areas of concern of social, psychological, and environmental significance?

As well, the adoption of shamanic healing by Western medicine may have an impact on indigenous source communities. What might those impacts be, and how does the appropriation of shamanic knowledge play out in the scheme of local identity and global transference? An anthropological investigation of this movement in the United States may serve to better understand some of the cultural implications in health care choices and notions of health and well-being, as well as support indigenous rights and the cultural survival of the oldest traditional healing practice in existence.

**Outline of this Dissertation**

Chapter 2 summarizes the aim of this research project and describes the means of data collection and data sources on which I base my findings. In chapter 3 I provide a literature review and theoretical background on the discussion of shamanism, a topic that has been written about more than any other in the field of anthropology. The data I collected through surveys, interviews, and ethnographic observation are presented in
chapters 4, 5, and 6. In my examination of two different approaches to combining shamanic healing and Western medicine, this study identifies two models, the “Individual Model” and the “Collaborative Model.”

Chapter 4 presents the “Individual Model” (Model I) in which my findings are based on ethnographic interviews with Western-trained health care practitioners who have also studied techniques of shamanic healing, and in many cases, combine these two practices in some manner in their professional practice. Chapter 5 presents the background on True North Health Center (True North) in Falmouth, Maine where I conducted my ethnographic research. And chapter 6 introduces the two resident shamanic practitioners at True North who work in collaboration with Western-trained health care practitioners, thus this is described as the “Collaborative Model” (Model II). An analysis of my findings, including a comparison of Models I and II, as well as the broader cultural implications of practicing shamanic healing techniques in the United States versus more traditional shamanic cultures, is presented in chapter 7. Chapter 8 provides discussion on the ethical considerations of appropriating indigenous knowledge as I argue in favor of universal practice of shamanism, though not without attention to economic concerns and sensitivity to cultural identity. Completion of the discussion of this study occurs in chapter 9 in which I highlight the broader considerations of the changing culture of – or needed changes to – the practice of biomedicine in the United States.
CHAPTER 2

STATEMENT OF PROBLEM AND RESEARCH DESIGN

Statement of Problem

As the practice of biomedicine spreads around the globe, the prevailing view frames biomedicine as an entire philosophy that creates a medical culture promoting a common set of values—considered by some to be “a key obstacle to widespread health care reform” (Wendland 2004:3). Yet more recent studies within the field of Critical Medical Anthropology (CMA) support the understanding that culture drives the practice of biomedicine rather than the other way around, and that “a reductionist Cartesian view of the individual may be less a product of medical education itself than of the [Western] setting in which it has been studied” (Wendlland 2004:63).

If one is of the mind that health care needs serious reform, the above finding may be disheartening to those living in a Western culture, i.e. it might seem more plausible to change an institution of medical education rather than an entire cultural paradigm around health and healing. However, this study highlights a subcultural movement within the United States health care system that appears to be inducing cultural shifts within the established field of conventional Western medicine. Furthermore, it denotes the possibility that a hybrid or syncretic system of health care might combine the experienced benefits of both biomedicine and traditional healing. Though many of the tenets of biomedicine are in direct opposition to those of shamanic healing, the two systems are

6 Making Doctors in Malawi: Local Exigencies Meet Global Identities in an African Medical School (May 2004) by Claire Leone Wendland is a dissertation in anthropology that examines physician training, identity, and practice in an economically poor, third-world African country. The author concludes that physician norms may be less the product of a bio-medical education than the societal material conditions and cultural context in which the medical students live.
able to coexist on a practical (and practiced) level (albeit not without some difficulty). And just as importantly, beyond the institution of medical practice, the adoption of shamanic practices may influence Western culture on a deeper, broader paradigmatic level.

**Aim**

This study investigates the adoption of shamanic healing by Western-trained health care practitioners working in the United States via surveys, interviews, and ethnographic observation. The investigator explores why and how a healing paradigm borne out of indigenous cultures oriented toward communal living and local economies is practiced within a biomedical health care system situated within a Western culture steeped in individualism, commercialization, and commodification.

**Objectives**

- To survey and interview Western-trained medical practitioners in the United States as to their motivations, implementation, and limitations with respect to the study and practice of shamanic healing techniques.
- To conduct an ethnographic analysis of a health care center in the United States that collaboratively provides both Western medicine and shamanic healing to its clients.
- To assess ways in which shamanic ideologies may cause and/or reflect shifts in existing Western notions of body, health, illness, and healing.
- To explore the controversies of a neo-shamanic movement with respect to identity concerns of traditional shamanic healers, and the impacts of a Western culture’s adoption of shamanic healing techniques on donor indigenous communities.
Choosing a Topic

It was a journey in itself to establish my doctoral dissertation topic, having initiated the conception and early stages of research on various other topics of interest before finalizing my study of Western shamanism. I was academically interested in the application of cross-cultural healing practices; and personally interested in social movements addressing environmental sustainability from a deep ecology perspective. Serendipitously one day I came across a newly published book entitled *Shaman, MD: A Plastic Surgeon’s Remarkable Journey into the World of Shapeshifting* by Eve Bruce 2002 that recounted a Western-trained physician’s foray into the world of shamanism, and her return to Western medicine with a newly-defined sense of what it meant both “to heal” and “to practice healing.” Her first chapter entitled “Looking Outside the Box” was a statement of exactly what I wanted to do with my research. I wanted to relay some kind of “cutting edge” – and on the edge – cultural practice that was not well recognized or well established (yet) within mainstream Western culture, but that provocatively pushed the envelope of cultural norm.

I began to research individuals and organizations that facilitated shamanic healing in the United States, including “Dream Change Coalition” (later renamed “Dream Change”) through which Dr. Eve Bruce first ventured to Ecuador to begin her own shamanic journey. I soon learned that the leading organization to prolifically introduce shamanic healing to the United States was the Foundation for Shamanic Studies (FSS), founded by anthropologist Michael Harner. I decided to embark on ethnographic participation and was soon in attendance at a “Basic Workshop” on shamanic journeying in San Francisco, California, led by Harner. It was March, 2002. I found the workshop
material compelling, adorned by Michael’s humorful stories and teachings. As I began to learn the technique of shamanic journeying, I decided shamanic practice in the United States was a topic well worth pursuing. Once on the FSS mailing list, I received the semi-annual FSS journal, “Shamanism,” in which the first annual meeting on “Shamanism in Medicine” was announced. There it was, an organized event for the very people I had envisioned as a possible cohort of subjects – a group I was not sure even existed beyond a few individuals such as Dr. Eve Bruce. Unfortunately, my graduate school budget did not allow me to attend the June 2002 meeting in Santa Fe, New Mexico. But I continued to research the topic and the following year received a discount rate to attend the second annual “Shamanism in Medicine” conference in Santa Fe, June 2003.

The cost of attending the conference was still very expensive for a graduate student budget, and as I walked into the conference headquarters, I felt that these few days would make or break my decision to pursue the topic of shamanic healing in Western medicine. Just prior to the conference, while reading the latest FSS journal, I spotted a solicitation requesting Western-trained medical practitioners who were also studying/practicing shamanic healing to respond to a survey. I had wanted to develop and circulate such a survey, but given the small membership of possible respondents, I did not feel I now could duplicate the effort. I wanted to find out who was facilitating this survey (which was not provided in the FSS journal) and their research objectives.

The conference was held at “Sunrise Springs,” a spa resort known for its natural, environmentally-friendly facilities and food service (i.e. no television, poolside bar, or candy and soda vending machines). It was quite pleasant, although I stayed at a lower-
priced motor lodge down the road where the amenities of bedside TV, styrofoam coffee cups, and recirculated indoor air were still available. I signed up for a three-day afternoon workshop with Cecile Carson, MD who spoke about the experience of integrating shamanic healing into a conventional medical practice. It was during the second day of Dr. Carson’s workshop that she announced that she had placed a notice in the FSS journal about a survey she was conducting on Western medical practitioners using shamanic healing. After the workshop I hurriedly approached Dr. Carson to talk about her research, intent, and goals for utilizing the data. And right there a collaboration was borne. In post-conference discussions, Dr. Carson agreed to share the survey results with me and we laid out our common interests in the data as well as our individual angles of analysis. Dr. Carson also agreed to serve as my outside dissertation committee member. Although our conversations of collaboration were preliminary at the conference, on my return trip home as my plane touched down on the tarmac at Bradley airport, I felt that I had finally “landed” a dissertation topic of import.

**Research Design**

In order to investigate the above objectives, the field research has been divided into two contrasting models of health care provision:

- **Model I: the Individual Model** (consisting of Western-trained health care practitioners who also have received training in shamanic healing, and in many cases, practice it in conjunction with allopathic medicine)

- **Model II: the Collaborative Model** (consisting of a group of healers working collaboratively at a health center of which two members are shamanic healers who do
not have Western medical training and a number of Western-trained health care practitioners who do not have shamanic healing training)

The table below outlines the samples and methods employed to carry this out.

**Table 1: Research Sample and Methods**

<table>
<thead>
<tr>
<th>Features</th>
<th>Model I</th>
<th>Model II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Across the United States (within 17 States)</td>
<td>True North Health Center Falmouth, Maine</td>
</tr>
<tr>
<td>Practitioner surveys</td>
<td>58</td>
<td>N/A</td>
</tr>
<tr>
<td>Practitioner interviews</td>
<td>27</td>
<td>26 (includes all health center practitioners and staff)</td>
</tr>
<tr>
<td>Client surveys</td>
<td>N/A</td>
<td>20</td>
</tr>
<tr>
<td>Client interviews</td>
<td>N/A</td>
<td>12</td>
</tr>
<tr>
<td>Method of data collection</td>
<td>open-ended interviews</td>
<td>participant observation and open-ended interviews</td>
</tr>
</tbody>
</table>

In addition, six interviews of nationally-renown shamanic healing trainers and/or advocates of indigenous rights were conducted.

**Data Sources**

Given the nature of this research topic, establishing an ethnographic research site was questionable. Except for the annual five-day conference on “Shamanism in Medicine,” there was no central location where Western-trained medical practitioners gathered or practiced this hybrid craft of healing. Surveys and follow-up interviews served as one means of accessing a disparate subculture, but the need for a research site was also apparent. During an interview with one of the survey respondents, I learned of True North Health Center (True North or TN) in Falmouth, Maine where Western-trained medical practitioners and two shamanic practitioners worked collaboratively. This
unique health center served as an additional source of data, and provided me with a means of a comparative study in which I examine two different models for incorporating shamanic healing into Western medicine in the United States. The two models based on my two different data sources are presented: (1) The Individual Model and (2) The Collaborative Model.

**The Individual Model**

The Individual Model (Model I) involved interviewing Western-trained health care practitioners who also had studied, and in some cases, were incorporating shamanic healing practices into their professional health care services. Dr. Carson provided me with copies of the completed surveys that she received (totaling 99) from which I collated the responses and identified the respondents that I intended to contact for follow-up interviews (see Appendix A for a copy of the survey distributed by Dr. Carson). Before I began the interview process, Dr. Carson and I co-signed a letter of thanks to acknowledge all those individuals who took the time to fill out the survey, and to let them know that I was working with her, and might contact them for a follow-up interview (see Appendix B). Based on the provided information in the surveys, I contacted respondents who: (1) included contact information (which was optional); (2) noted Western medical training (i.e. MD, DO, DDS, PA, and RN); and (3) stated to be practicing in the United States. It should be noted that respondents who were trained alternative healers or non-medically-trained counselors (e.g. psychologists, therapists, and social workers) were not included in the interview list. Although it appears to be more common for Western-trained professionals in the field of counseling, rather than physical medicine, to combine some form of shamanic healing in their practice, my research focused on those medical
professionals who were trained within the biomedical model to treat physical ailments and conditions. The diametrical contrast of many biomedical tenets to those of shamanic healing offers an especially interesting study of a syncretic healing protocol.

The 99 surveys ultimately provided a pool of 58 possible interviewees (based on their medical training and whether they provided contact information). Of those 58 respondents, I was able to conduct 21 interviews in person or by telephone. (Note: Some respondents were not reachable through the provided contact information, due to problems with the email address and/or telephone number; or unavailable for an interview.) Whenever possible, I first contacted respondents by email, but telephoned when an email address was not provided or there was no response. With each respondent that I contacted, I provided a short reminder of who I was and my research interests, a PDF file of the acknowledgement letter previously sent to them by Dr. Carson and myself (if contact was via email), and a request for an interview (in person if the interviewee lived in close proximity or in most cases, by telephone). If the individual agreed, once a date and time was arranged, I followed up with an email confirmation and attached a PDF file of the Informed Consent Form for my Human Subjects Review requirement, and asked the interviewee to email me a note of acknowledgement and agreement (see Appendix C). In the end, I was able to interview a total of 21 respondents from the survey list. Through referrals, I was also able to arrange for another six interviews of western-trained medical practitioners who also practice shamanic healing, thus interviewing a total of 27 individuals within the “individual practitioner model” category. [See “Table 2. Shamanism in Medicine Survey Results” on pages 36-38 for a tabulation of survey data.] For a list of interview questions for practitioners, see Appendix D.
The Collaborative Model

As stated earlier, I felt it imperative to locate an ethnographic research site as another source of cultural analysis. After an extended search, I arranged to spend several months at the True North Health Center in Falmouth, Maine. In June 2005 I attended the first annual “Society for Shamanic Practitioners” (SSP) conference in Pacific Grove, California. SSP, and its sponsoring conference, evolved out of the “Shamanism in Medicine” gathering that was discontinued. Many of the same organizers now volunteered their efforts to support SSP and sat on its founding Board of Directors. At the conference, I attended a three-day afternoon workshop facilitated by True North’s shamanic practitioners, Allie Knowlton and Evelyn (Evie) Rysdyk. Upon their suggestion, I submitted a formal research proposal to them (see Appendix E) and received an email July 31, 2005 that it had been accepted.

I met with Allie and Evie at their True North office at the beginning of September 2005 and the next week officially began my ethnographic experience at True North. However, following attendance at my first meeting (referred to as “Circle’ in True North parlance), I learned that I had to go through yet another review process before I could continue. After submitting additional paperwork followed by an internal discussion among TN staff, and attendance at a HIPAA training, I received formal approval (in

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7 HIPAA is the United States Insurance Portability and Accountability Act of 1996. There are two sections to the Act. HIPAA Title I deals with protecting health insurance coverage for people who lose or change jobs. HIPAA Title II includes an administrative simplification section that deals with the standardization of health care-related information systems. In the information technology industries, this section is what most people mean when they refer to HIPAA. HIPAA establishes mandatory regulations that require extensive changes to the way that health providers conduct business. HIPAA seeks to establish standardized mechanisms for electronic data interchange, security, and confidentiality of all health care-related data. The Act mandates: standardized formats for
writing) to conduct ethnographic research at True North. This arrangement included an agreed upon set of stipulations concerning the protection of patient confidentiality (see Appendix F).

In total, I spent 34 days at True North (usually one or two days a week) between September 2005 and June 2006, during which I sat in on a total of 32 “circles” (i.e. staff meetings of one sort or another), and conducted 26 in-person interviews with all available TN Circle members (i.e. staff and practitioners). In an effort to make appointments with as many of the TN Circle members as possible, I: (1) periodically made announcements at the Circles that I attended, (2) left a sign-up sheet with an explanatory letter attached in the “announcement” area of TN’s office (see Appendix G); and (3) periodically emailed members to arrange for an interview. For a list of interview questions for TN practitioners and staff, see Appendix H.

I also developed a client survey that I gave to Allie and Evie to offer to their clients (see Appendix I). Over the course of the study period I received 20 client surveys, of which six were filled out anonymously and the other 14 voluntarily provided contact information for a possible follow-up interview. I was able to arrange interviews with 12 of the respondents, some in person and some via telephone. For a list of interview questions for TN clients, see Appendix J.

all patient health, administrative, and financial data; unique identifiers (ID numbers) for each health care entity, including individuals, employers, health plans and health care providers; and security mechanisms to ensure confidentiality and data integrity for any information that identifies an individual (http://searchdatamanagement.techtarget.com/sDefinition/). Most important for my research at True North is this last aspect of HIPAA-patient confidentiality.
## Table 2: Shamanism in Medicine Survey Results

<table>
<thead>
<tr>
<th>Total Responses</th>
<th>99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anonymous (or name only)</td>
<td>8</td>
</tr>
<tr>
<td>Name and contact information provided</td>
<td>91</td>
</tr>
</tbody>
</table>

### Location
- International: from Canada (4); Germany (1); and Ireland (1) | 6 |
- United States: from 23 different states | 85 |

### Practitioner Categories of Respondents

<table>
<thead>
<tr>
<th>Interviewed</th>
<th>Type of Practitioner</th>
<th>(Y = Yes; N = No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Medical Doctor (MD)</td>
<td>27 (4*)</td>
</tr>
<tr>
<td>Y</td>
<td>Osteopath (DO)</td>
<td>2</td>
</tr>
<tr>
<td>Y</td>
<td>Dentist (DDS/DOC)</td>
<td>2</td>
</tr>
<tr>
<td>Y</td>
<td>Physician Asst./Assoc.</td>
<td>2</td>
</tr>
<tr>
<td>Y</td>
<td>Nurse (BSN/MSN/RN)</td>
<td>25 (2*)</td>
</tr>
<tr>
<td>N</td>
<td>Chiropractor (DC)</td>
<td>2 (1*)</td>
</tr>
<tr>
<td>N</td>
<td>Naturopath (DN)</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>Psychologist (Ph.D.)</td>
<td>10 (1*)</td>
</tr>
<tr>
<td>N</td>
<td>Therapist/Social Worker (MSW +)</td>
<td>17</td>
</tr>
<tr>
<td>N</td>
<td>Acupuncturist</td>
<td>2</td>
</tr>
<tr>
<td>N</td>
<td>Massage Therapist</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>Childbirther (doula)</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>Clinical Chaplain</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>Non-Western trained (shamanic, reiki, herbalism)</td>
<td>3</td>
</tr>
<tr>
<td>N</td>
<td>Other (medical technologist, illustrator, admin)</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>99 (8*)</td>
<td></td>
</tr>
</tbody>
</table>

* Anonymous (or name only) surveys

### Surveys Analyzed (based on respondent’s Western medical training):

<table>
<thead>
<tr>
<th>(Y = Yes; N = No)</th>
<th>99%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Doctor (MD)</td>
<td>27 (47%)**</td>
</tr>
<tr>
<td>Osteopath (DO)</td>
<td>2 (3%)**</td>
</tr>
<tr>
<td>Dentist (DDS)</td>
<td>2 (3%)**</td>
</tr>
<tr>
<td>Physician Asst./Assoc. (PA)</td>
<td>2 (3%)**</td>
</tr>
<tr>
<td>Nurse (BSN/MSN/RN)</td>
<td>25 (43%)**</td>
</tr>
<tr>
<td>TOTAL</td>
<td>58 (99%)**</td>
</tr>
</tbody>
</table>

Percentage of surveys analyzed of the total number of surveys received | 59%

** Percentage of respondents of analyzed surveys (rounded off)

---

8 Data tabulation by Lori Thayer. Data Source: “Survey of Integrating Shamanic Principles in to Western Medical Practice” designed by Cecile Carson, MD.
I. Explicit Survey Questions

Please note that some respondents did not answer all the survey questions, therefore the totals for each question may vary.

1. Received Formalized Shamanic Training:
   - FSS: Basic workshop: 8 (14%)
   - FSS: Basic and other workshops: 9 (16%)
   - FSS and Other: 28 (48%)
   - Other (non-FSS): 10 (17%)
   - None: 3 (5%)

2. Use in Medical Setting:
   - Overt*: 18 (31%)
   - Covert*: 37 (64%)
   - Neither: 12 (21%)
   - No longer practicing in Medical Setting: 2 (3%)

   * Some individuals checked both overt and covert

3. Workplace Setting:
   - Private Practice/Home office: 19 (33%)
   - Outpatient/Clinic: 12 (21%)
   - Hospital/ER: 16 (28%)
   - Other (e.g. nursing home, long-term care, hospice, home health care, research center): 10 (17%)

II. Open-ended Comments (i.e. information recorded if provided, but explicit questions not asked regarding these areas of concern)

4. Workplace/Institutional Acceptance
   - Explicitly accepted/welcomed: 4
   - Explicitly unaccepted/not permitted: 10

5. Patient Application
   - Physical/Organic conditions: 8
   - Emotional/psychospiritual: 9
   - Diagnostic: 8
   - General Care/Intention: 22
   - Dying Process (Psychopomp): 8
6. Use of Shamanism other than Patient Care
   Personal  10
   Practice on Family/Friends  2
   Teaches/Leads Classes in Shamanism  3
   Participates in Drumming/Shamanic Circle  6
   Non-patient work-related (e.g. dealing with Colleagues; meeting prep)  2
   Other (e.g. land and buildings; birthing ceremonies)  3

7. Financial
   Charges Fee  0
   Doesn't Charge Fee  1
   Bills to Insurance  1

A few noteworthy comments:

- one respondent stated that her shamanic training was beneficial in terms of working with patients from “shamanic-based” cultures; however, she was often not recognized explicitly as a shaman by these patients due to her sex and ethnicity
- one respondent raised the concern about the expense of shamanic training and the capitalistic approach to using it in the United States
- a handful of respondents noted that a difficulty in using shamanic healing techniques in their medical setting is the lack of time
- one respondent expressed concern that overt use would cause them to be discredited by their peers
- many expressed a desire to study/use shamanic healing techniques to a greater degree in the future
- many expressed interest in the survey results in hopes of learning about other healthcare practitioners’ experiences, and about approaches to incorporating shamanic healing techniques into a Western medical setting
It was truly an engaging experience to spend time at True North and worth the six-hour plus roundtrip commute between my home in Northampton, Massachusetts and True North’s offices. Appendix K provides a copy of a letter of departure that I gave to each TN member in which I thank them for their time and ask that they contact me if they have any further experiences collaborating with Allie and Evie that they would like to share. In Appendix L I have included a number of photos of True North, both exterior and interior; and in Appendix N a photo of the two shamanic practitioners, Allie Knowlton and Evie Rysdyk.

The two aforementioned comparative health care models along with other means of gathering information resulted in six categories of data collection:

**Western-Trained Medical Practitioners**

As stated, this group consists of practitioners holding medical degrees including MD, DO, DDS, PA, RN, and RPH. The 27 members of the interview group work in 17 different states (no more than three per state), and a range of clinical settings including hospitals, government-funded health services, private group practices, solo practices, nursing homes, and hospices. Some are general practitioners while others specialize in internal medicine, pediatrics, geriatrics, psychiatry, rehabilitation, palliative care, plastic surgery, and neurology, as well as osteopathy, dentistry, and pharmacology.

**True North Health Center**

True North opened its doors in 2002 in Falmouth, Maine. It is the only health care facility in the United States known to provide a collaborative model of treatment with on-staff Western-trained medical practitioners and two shamanic healers. True North is the ethnographic site for this study and the basis for the Collaborative Model
(Model II) of investigation. Between September 2005 and June 2006, I attended a total of 32 meetings (referred to as “Circles”) and conducted interviews with 26 TN practitioners and staff.

**Clients**

Given the difficulty of randomly surveying clients of individual practitioners identified in Model I, it was determined that attempting to include clients as a source of data was beyond the scope of this study. However, by nature of the research conducted at True North, clients receiving services under the Collaborative Model (Model II) were surveyed and when possible, interviewed. I received 20 surveys and was able to conduct interviews with 12 of the survey respondents.

**Trainers / Directors of Relevant Organizations**

Another categorical source of information comes from organizations whose mission is to address the study and preservation of traditional shamanism, and in some cases, offer shamanic healing trainings to Westerners. Four prominent organizations engaged in this work are: (1) The Amazon Conservation Team founded by Mark Plotkin (1995); (2) Dream Change founded by John Perkins (early 1990s); (3) The Foundation for Shamanic Studies, Inc. founded by Michael Harner (1985); and (4) The Center for Spirited Medicine founded by Connie Grauds, RPH (2001). The founder of each of these organizations was contacted with a request for an interview. Mark Plotkin, John Perkins, and Connie Grauds complied, while Michael Harner replied that he was unavailable. Four other individuals of importance were also identified and interviewed under this category of significance.
Workshops / Conferences / Gatherings

As early as spring 2002, I began to attend shamanism-related workshops, conferences, and gatherings and have continued to do so to the present. Through participant-observation at these events, a good deal of information can be gleaned from such gatherings of interested individuals, especially given that conferences and workshops have become the most communal site of such cultural interchange and activity for various alternative, spiritually-related movements, including the practice of shamanism. This study does not include formal discussion and analysis of such experiences; however, they have served as both a mode of education for me personally as well as a cultural backdrop for this study.

Literature

The literature covering various aspects of shamanism in the field of anthropology alone is vast. As well, other fields of study, such as sociology, psychology, and history, also offer many articles and books on shamanism. There are also innumerable articles in popular magazines that discuss the phenomenon of neo-shamanism. In other words, there was no dearth of discussion on many of the topics of shamanism; however, very few articles present the topic covered in this dissertation.

Human Subjects Review

Prior to conducting interviews, I submitted a Human Subjects statement for my research to the Human Subjects Review Coordinator in the Department of Anthropology at the University of Massachusetts. I received written approval on March 7, 2005 (see Appendix C). This allowed me to begin the interview stage of my research.
Interview Process and Utilization

I began each interview with a brief overview of my research and asked the interviewee if he or she had any questions. The interviewee was also reminded about the agreement of confidentiality elaborated in the Informed Consent Form which I developed as part of my compliance with Human Subjects’ research requirements.

The interviews were conducted in an unstructured, open-ended format. With each practitioner, the interviewee was asked to state his or her Western medical background, but from that point on a set of questions was woven into the conversation as deemed appropriate for the discussion that ensued. Interviews with non-practitioners (e.g. TN staff, clients, and shamanic trainers/advocates) began with a question asking the interviewee’s background as deemed relevant.

The objective of utilizing an open-ended format was to provide the interviewees with the opportunity to express their thoughts and tell their stories without being confined to a rigid, ordered set of questions. I found that I was always able to cover all the questions that seemed relevant for that individual within my list of previously-outlined questions. At the end of every interview, I gave the interviewee the opportunity to state anything else that he or she felt relevant to the discussion. The majority of my interviews ran anywhere from 45 – 90 minutes, with a few running a bit less and a few as long as two hours. I should also add that I found all my interviewees to be very willing to share their thoughts and experiences, and often expressed interest in the final product; as well as commending me for doing research that they felt was important to furthering the movement of adopting shamanic healing into Western medicine. The bulk of my interviews were conducted between March 2005 and June 2006.
In almost all cases, interviews were tape recorded, whether conducted in person or by telephone. Each interview tape was catalogued and notated using a transcription machine. Interviews were not transcribed given the length of each interview and number of interviews conducted (a total of 71). Rather the information, stories, reflections, and quotes deemed relevant were notated and categorized by topic.

As stated in the Informed Consent Form, serving as the primary investigator, I am the only person who has access to the tapes and interview notations. All provided information has been kept confidential except where it has been reported in an anonymous fashion, or where the interviewee has given me explicit permission to use his or her interview material with identifiable references, such as their real name or other specific information. Within this dissertation, there are many quotes provided by interviewees; however in all cases except where explicit permission is granted to use an interviewee’s real name, an alternate or anonymous moniker is used. In the case of individual practitioners and other relevant interviewees, a first name pseudonym is used, accompanied by the initials of their professional medical title where applicable. In the case of True North members, they are simply identified numerically (e.g. TN member #1, TN member #2, etc.).

**Research Limitations / Future Explorations**

The author realizes that the information presented in this study is the beginning of a qualitative examination of the cultural phenomenon of shamanic healing entering mainstream medicine and does not include a statistical assessment of how many or where such Western-trained medical practitioners are incorporating shamanic healing into their practice. Rather, it paves the way for later such possible studies. As well, the informants
for the Individual Model are not a result of a random sample, but rather make up a set of individuals willing to come forth and offer their time and thoughts to the researcher. In most cases, they are also individuals who are somehow affiliated with the FSS, and have specific training in “Core Shamanism,” though not exclusively (see chapter 3 for an explanation of “Core Shamanism”). Thus there may be various other Western-trained health care practitioners who have studied shamanic healing through other venues, but who were not made aware of this study, and therefore did not fill out a survey.

Furthermore, it is realized that what most likely will draw shamanic healing into the mainstream is reports of its efficacy, which this study does not attempt to measure. In part, the author believes it is important to get a broad understanding of the movement before embarking on detailed studies, i.e. to get a picture of the landscape before attempting deep excavation. As well, because the ideology of shamanic healing is so divergent from that of biomedicine, it may not be easy to measure its efficacy at this point in time. Healing has a much broader definition in the realm of shamanism, so what might be considered a healing effect in shamanism might be overlooked within the biomedical/Western scientific model of assessment.

Sometimes attempts to measure energetic–spiritual shifts within the framework of Western medicine is like trying to measure wind velocity of a storm with a thermometer. We may not have the proper tools or orientation to attempt adequate studies on efficacy and results until we have a broader cultural understanding of the meaning and role of shamanic healing. One MD noted the difficulty in measuring the efficacy of shamanism because of so many compounding factors (Roland, MD). Another practitioner stated,
“There’s now good science supporting the mind–body connection, but the spiritual piece is the next frontier” (Stan, DO). It’s a difficult task at hand, but an important next step.
A Yakut legend tells of the first shaman’s possession of power greater than God. God saw the Yakut shaman, whose body was made of a mass of snakes, and sent down fire to burn him. But a toad emerged from the flames, and from this creature came the ‘demons’ who in turn, provided the Yakut with their outstanding shamans and shamanesses (Eliade 1964:68).

A Buryat story tells of the beginning when there were only gods in the west and evil spirits in the east. The gods created man, and he lived happily until the time when the evil spirits spread sickness and death over the earth. The gods decided to give mankind a shaman to combat disease and death, and they sent the eagle. The eagle returned to the gods and asked them to give him the gift of speech, or else to send a Buryat shaman to men. The gods sent him back with an order to grant the gift of shamanizing to the first person he should meet on earth. Returned to earth, the eagle saw a woman asleep under the tree, and had intercourse with her. Some time later the woman gave birth to a son, who became the ‘first shaman.’ According to another variant, the woman, after her connection with the eagle, saw spirits and herself became a shamaness (Eliade 1964:69).

Above are two of many examples of shaman creation stories, one depicting the shaman as a nefarious competitor of God, endowed with power from demonic sources; and the other depicting him or her as a gift of the gods to the world to provide a defense against evil. Mircea Eliade (1964) provides a selection of shaman creation stories in his treatise *Shamanism: Archaic Techniques of Ecstasy* in which shamans are portrayed in different lights, both sinister and benevolent. Since ethnographers began to write about shamans\(^9\), the archetypical image of the shaman has varied in extremes through different time periods and theoretical genres, ranging from a demonized and pathological miscreant to cunning trickster to the wounded—but exquisitely sensitive and gifted—

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\(^9\) The first published account of shamans in various Siberian communities is *North and East Tartary* 1692 by the Dutch explorer, Nicolaas Witsen (Znamenski 2007:5).
healer. In his study of the Aguaruna Jivaro of Peru, Michael Brown (1988) references the “shaman–sorcerer complex,” the tribe’s belief that if a shaman has the power to heal, than he also has the ability to effect sorcerous acts.

However, in the popularization of shamanism in Western society in recent years, the shaman’s role has been distilled and magnified as benevolent healer, with little preoccupation for potential ill-deeds such as sorcery, which is viewed more as a vestigial artifact of traditional societies. Western shamanism in comparison to indigenous shamanisms, “tends to deny the reality of intrinsically nefarious spirits (von Stuckard 2002:775). “In traditional shamanism there is usually a battle between good and evil; witches attack; spirits can be beneficial or dangerous . . . but in Neo-shamanism there is a tendency to see the universe and the spirit world as friendly or benign” (Townsend, 2004:5). [Though Townsend notes that Michael Harner does address issues of evil in his Core Shamanism trainings.]

Background

Mircea Eliade described shamanism as a religious phenomenon of Siberia and Central Asia (though he later states that it is not confined to this region) and further defined it as an [archaic] technique of ecstasy (1964:4). The word shaman comes from the Tungusic word saman, as described by the Evenki who were a small group of Tungus-speaking hunters and reindeer herders in Siberia (Vitebsky 1997), although some historians erroneously traced it to Oriental roots. Historian Andrei Znamenski (2007) provides a strong argument against such Sanskrit etymology, as does Laufer (1917). Znamenski also notes that the term ‘shaman’ was introduced into Western literature and scholarship, not by Russians, but by eighteenth century Germanic explorers and scientists
who wrote about native Siberian spiritual doctors or *schaman* (2007:5), though Laufer (1917) states unequivocably that it was the Russian (chiefly Cossack) explorers and conquerors of eastern Siberia in the latter part of the seventeenth century who first heard and recorded the term among Tungusian tribes.\(^\text{10}\) There is much debate as to when shamanism first came into practice, but references range in the Upper Paleolithic anywhere from 10,000 to 40,000 y.a. (based in part on archeological analysis of rock art, though such interpretive analysis has raised much debate over what can or cannot be shamanistically-derived; see Bower 1996; Kehoe 2002; Klein et al. 2002; Lewis-Williams 2003; Price 2001). Anthropologist Barbara Tedlock (2005) further argues that the very first shamans were female, based on archeological finds (interpreted to be of shamanic significance) at the Upper Paleolithic excavation site of Dolni Vestonice in the Czech Republic.

The study of shamanism has been performed from various theoretical perspectives. Two academics who introduced shamanism to the larger public are Mircea Eliade (1907-1986), a Romanian-born philosopher and religious scholar who took an academic approach through a comparative literature review; and Carlos Castenada (1925-1998), a Peruvian-born anthropologist who provided experiential accounts (now known to be an embellishment of his fieldwork). Eliade took a phenomenological approach to the study of shamanism, attempting to pinpoint the spiritual and ritualistic commonalities of shamanic practice among different cultures. Eliade’s introduction to his treatise, *Shamanism: Archaic Techniques of Ecstasy* 1964 compares the role of historical

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\(^{10}\) For in-depth historical overviews, see *Shamanism and the Eighteenth Century* 1992 by Gloria Flaherty; *Shamans through Time: 500 Years on the Path to Knowledge* 2001 edited by Jeremy Narby and Francis Huxley; and *The Beauty of the Primitive* 2007 by Andrei Znamenski.
ethnology, psychology, and sociology with history of religion, stating that “in the last analysis, it is for the historian of religions to synthesize all the studies of particular aspects of shamanism and to present a comprehensive view which shall be at once a morphology and a history of this complex religious phenomenon” (p. xiii). Michael Harner, founder of the Foundation for Shamanic Studies (FSS), and deemed the “father of western shamanism” has provided a similar approach through his advocation and teachings of what he calls “Core Shamanism.”

There are, of course, numerous ethnologies and ethnographies of specific shamanic cultures, each with its own cultural particularities.

**Terminology and Theoretical Perspectives**

It was not until the 1900s that the term ‘shaman’ was used to refer to Native American spiritual healers, instead of the more generic term, ‘medicine wo/man’ (Znamenski 2007:63). While some academics continue to use the term ‘shaman’ interchangeably with ‘medicine men’, ‘sorcerers’, and ‘magicians’, other scholars have drawn distinctions, such as one who engages in “magical flight” (Eliade 1964:5) or one “who can will his or her spirit to leave the body and journey to upper or lower worlds” (Vitebsky 1997:1) or “a social functionary who, with the help of guardian spirits, attains ecstasy in order to create a rapport with the supernatural world on behalf of his group members” (Hultkrantz 1985:512). Still other academics have argued that the use of the term ‘shaman’ continues to be used too broadly, admonishing that “there is a pressing need to create a more refined, nuanced terminology that would distinguish, cross-

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11 “Core Shamanism is the universal or near-universal principles and practices of shamanism not bound to any specific cultural group or perspective, as originated and developed by Michael Harner” (FSS website at http://www.shamanism.org/workshops/index.php).
culturally, among the many different kinds of roles currently lumped together under the vague and homogenizing rubric of ‘shaman’” (Klein et al. 2002:1). The pluralization of ‘shamanism’ in the 1980s was one attempt to limit the universalization of the practice (Atkinson 1992:308). However, social scientist Alice Kehoe (1996) argues most vociferously that the term ‘shamanism’ should be restricted to referencing specific practices of Siberian (or subarctic) nations as well as obviate tendencies of primitivism in which European notions romanticize the preservation of primal or Paleolithic religious practices by static non-Western societies.

Yet Barbara Tedlock, anthropologist and shaman-initiate, points out that shamanism “lacks an institutional framework and central figure—there is no Dalai Lama or Pope—[and therefore] appears, disappears, and reappears in varied historical and political settings” (2005:27). Meanwhile another theorist has argued that shamanic rituals offered survival advantages and thus biological selection favored hypnotizability as a trait, which in turn supports the argument that shamans have been present at some point in time throughout hunting and gathering societies (McClenon 1997). Archaeologist Peter Furst suggests the term *shamanic worldview* as “a common property of humankind” instead of conceiving the notion of a universal shamanism (1994:2). Devotees of neo-shamanism in general consider the practice of shamanic precepts as a form of spirituality that exists beyond the confines of geography or ethnicity.

12 James McClenon supports the theory that hypnotizability is a genetically selected trait. Shamanic/hypnotic suggestions may reduce pain, enhance healing, control blood loss, facilitate childbirth, and alleviate psychological disorders. Therefore those more responsive to such suggestions are hypothesized to have a survival advantage over the less susceptible. Such selection has supported the long-term practice of shamanism (*Journal for the Scientific Study of Religion* 1997, 36(3):345-354).
Furthermore, until recent years, the majority of Western academics who came into contact with shamans often described them with disdain: “that motley class of persons, found in every savage community” (originally quoted in 1908) (Dixon 2001:64) or portrayed them as pathological or psychologically imbalanced, even making up a religious order resulting from a “selection of unstable people” (Znamenski 2007:80). In many societies around the world, traditional shamans have suffered at the hands of genocidal movements against their craft. Five hundred years ago, conquistadors, missionaries, and others in the name of Christianity began eradicating shamans and their practices among North and South American Indians, as a means of expunging devil-worshippers. 13 In Zimbabwe (then Rhodesia), shamanism was outlawed by the Witchcraft Regulations of 1895 and the Witchcraft Suppression Act of 1899. In the 1930s and 1940s, Siberian shamans were viewed as counter-revolutionaries to Stalinism during “the Great Purges.” Only recently since the fall of the Soviet Union have surviving shamans been able to resurface without fear of retribution. 14 In the 1980s and early 1990s the Shining Path revolutionaries of Peru (a Maoist guerilla organization) assassinated shamans. And these are just a few of many examples of localized extermination efforts wielded against shamans. Today activities of neocolonialism, resource capitalism, and medical hegemony continue to thwart the survival of traditional shamans, many of whom are elderly with few tribal members to pass on their skills for perpetuation.


14 See Shamanism in a Post-Modern Age 1996 by Mihaly Hoppal for an overview of the contemporary revival of shamanism among Altaic peoples.
Franz Boas’ relativistic approach to anthropology—in his attempt to counter theories of cultural evolutionism [Edward B. Tylor (1871), Lewis Henry Morgan (1877), and Herbert Spencer (1877)]—provided a more humanistic approach to cultural interpretation in the early 1900s, yet also held to an iconic representation of indigenous society that influenced perspectives on Native American shamanism.\(^{15}\) Claude Levi-Strauss is hailed for shifting views on shamans, from psychotic to psychoanalyst, but Levi-Strauss also qualified a shaman’s power as a consequence of performance, rather than legitimate skill in the healing arts. In his essay, “The Sorcerer and His Magic,” Levi-Strauss emphasizes the power of communal belief to be preeminent, that cure by “magic” is a “consensual” phenomenon (1963a:168-169). As he demonstrates his argument further through a discussion on Franz Boas’ recording of Quesalid, a Kwakiutl Indian who reluctantly becomes a veritable shaman, Levi-Strauss writes that “Quesalid did not become a great shaman because he cured his patients; he cured his patients because he had become a great shaman” (1963a:180). Jane Atkinson’s observation of a drumming ritual (mabolong) of the Indonesian Wana tribe describes the aim of the ceremony to be less about medical healing, and more for the purpose of “general entertainment and shamanic self-aggrandizement (1987:345).

Mircea Eliade also referenced “the dramatic structure of the shamanic séance,” and “the sometimes highly elaborate ‘staging’ that obviously exercises a beneficial influence on the patient” (1964:511); yet he does not reduce shamanic practices purely to theatrics. In his epilogue he sums up the functions of shamans as defenders of “life, health, fertility, the world of ‘light’ against death, diseases, sterility, disaster, and the

world of ‘darkness’;” their universal “struggle against what we could call ‘the powers of evil’” (1964:509).

In the mid to late 1900s, post-modernism took hold, and theorists such as Clifford Geertz described shamanism as a “desiccated” and “insipid” ethnographic typology (1966:39) and Michael Taussig, through his research of Indians in Columbia who suffered from exploitative working conditions by the rubber industry, declared the notion of a shaman to be “a made-up, modern, Western category” reflecting an idealized image of indigenous peoples (1987:57). Psychologist Stanley Krippner provides a most interesting assessment of changing perspectives on shamanism over the centuries, presenting points and counterpoints to differing categories that he labels accordingly: “demonic,” “charlatan,” “schizophrenia,” “soul flight,” “degenerative and crude technology,” and “deconstructionist.” Most importantly, he comments self-reflexively that “Western interpretations of shamanism often reveal more about the observer than they do about the observed” (2002:963).

In the 1990s, theorists such as Jeremy Narby explored shamanism in comparative terms to Western science, thus attempting to universalize shamanic concepts through biology. Narby relates the twisted vine of ayahuasca to the twisted ladder of DNA, stating that “according to my hypothesis, DNA [is], like the axis mundi, the source of shamanic knowledge and visions” (1998:125) and goes on to assert that “what scientists

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16 In Clifford Geertz’s essay, “Religion as a Cultural System” 1966, he points out that his concern regarding the anthropological approach to studying religion is that it focuses on the broader “social-structural and psychological processes” while neglecting the “analysis of the system of meanings embodied in the symbols which make up the religion proper” (p. 42). Interestingly, many theorists from other disciplines have critiqued anthropology’s approach to studying shamanism as being too culture-specific, rather than too structuralist in attempts at highlighting underlying universals.
call DNA corresponds to the animate essences that shamans say communicate with them and animate forms of all life” (1998:132).

Yet even to the present, literature reviews of shamanism are critiqued for the many authors’ a priori assumptions of its existence and puts into question the use of the term. “Lack of a clear delineation of shamanism for scientific purposes is especially crucial in light of the postmodern and poststructural critiques of cultural theory.” Furthermore, given the “the recent attempt to incorporate so-called shamanic techniques of modalities into contemporary health care practices, the need for a clear understanding of the phenomenon is even more essential today” (Jones 2006:5).

While cultural relativity and post-modernist anthropology tends to look at the specifics of cultural practices, requiring definition through a descriptive framework within a cultural context, other theoretical approaches in fields such as psychology and religious studies, that more often gain wider public interest, draw on the generalized patterns and universal commonalities. Anthropologist Jane Atkinson notes that Western attention to shamanism was “spawned by the drug culture of the 1960s and 1970s, the human potential movement, environmentalism, [and] interests in non-Western religions” (1992:322) rather than via anthropological accounts, especially post-modern deconstructionist critiques. Scholars such as Mircea Eliade, Carl Jung, and Joseph Campbell “recognized the autonomy of the sacred” and “explored the timeless archetypes of these beliefs” which “fits well with the expectations of Western seekers of tribal spirituality” (Znamenski 2007:227). Ethnographers such as Edith Turner (1992; 1997) are famous for “going native,” attempting to experience what their indigenous informants experience in shamanic rituals.
Anthropologist Michael Harner (1980) also describes his personal experiences imbibing ayahuasca with the Conibo in Peru and the Shuar (Jivaro) in Ecuador and brings Eliade’s theoretical analysis full-circle in his design of “Core Shamanism” (see footnote #11 on page 49) in which he draws on the commonalities of shamanic ritual outside of culturally contextualized practices. It is through Harner’s founding of FSS in the United States and its programmatic workshops and teachings sponsored in the United States as well as Europe that has introduced the practice of shamanism in the West more than any one other text or program. This of course is not without some ridicule. Although Harner may not be able to avoid any insertion of cultural influence, namely his own Western upbringing, he has gone to great efforts to avoid cultural appropriation of any one indigenous shamanic group. And in doing so, he has made certain universal practices more accessible to Westerners. Although there are cultural purists who might argue that even the design of Core Shamanism is a form of appropriation, this paper presents many arguments to the contrary. Michael Harner has provided a source of personal empowerment and spiritual development for many, while also directing efforts toward supporting the revitalization of shamanic practices in traditional shamanic societies.

Although there are countless ethnographies of specific shamanic communities, the adoption of shamanic practices in Western medicine is most readily built on the practice of Core Shamanism. Yet in its foray into Western culture, shamanism (or what some

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refer to as neo-shamanism or urban shamanism\textsuperscript{18} has invariably provided a new cultural context in which to define and study a new shamanic approach. Thus the shamanism examined in this study is both generic and culturally-derived at the same time.\textsuperscript{19} Absent a universally-accepted definition of shamanism, this study bases its analysis on the practice of both core and culture-specific shamanisms in the United States with the understanding that many individuals have readily, for one reason or another, expanded their framework of reality to include the (perceived) phenomenon of shamanic events.

**The Role of the Shaman**

The role of the shaman has been described in various ways, such as one who maintains a balance between the natural and supernatural worlds, between the physical and the spiritual (Plotkin 1993). Specific tasks of shamans in traditional societies included: contacting spirits and supernatural entities; controlling the movements and lives of animals; changing the weather; and healing the sick (Lewis-Williams 2003). Which task historically was the original goal of the shaman, providing sustenance or meeting medical needs of the community, is debatable (Znamenski 2007:324–325). In carrying out such tasks, a distinctive feature of the shamanic technique is travel to the three worlds: the Upper, Lower, and Middle Worlds. The shaman specializes in a séance or ecstatic trance “during which his [or her] soul is believed to leave his [or her] body and ascend to the sky or descend to the underworld” in order to connect with his (or her)

\textsuperscript{18} For a definitional distinction between shamanisms: traditional, core, neo-, and urban, see *Individualist Religious Movements: Core and Neo-shamanism* 2004 by Joan B. Townsend.

\textsuperscript{19} See “Shamanism from Ecuador to Chicago: A Case Study in New Age Ritual Appropriation” 1995 by Paul Johnson for an analysis of neo-shamanism and its own distinctive cultural matrix.
helping spirits, be they “the soul of a dead person, a ‘nature spirit’, a mythical animal, and so on” (Eliade 1964:5–6). Inducing such a state of altered consciousness may be done through the ingestion of substances such as the fly agaric mushroom (Eurasia), peyote (North America and Mexico), or ayahuasca\textsuperscript{20} (South America); or may result in rhythmic activity such as chanting, dancing, or listening to the repetitive beat of a drum.

In modern parlance, the shaman trance is referred to as a “journey” whereupon the person journeying leaves ordinary states of reality (OR) to travel through non-ordinary states of reality (NOR). A basic “principle in shamanism is that there are two realities and that the perception of each depends on one’s state of consciousness. Therefore, those in the ‘ordinary state of consciousness’ (OSC) perceive only OR. Those in the ‘shamanic state of consciousness’ (SSC) are able to enter into and perceive NOR” (M. Harner 1999:1). In NOR, the person journeying travels to the Upper World to meet their “spirit” guides and to the Lower World to meet their animal guides or plant spirits; and may also travel through the NOR of the Middle World which is the Earthplane to meet deities such as fairies and gnomes, spirits of the elements, deceased humans who remain in the Middle World, etc. Usually a person acquires a “power animal” during their initiatory shamanic journey, that may occur in their own journey or via a shaman/shamanic healer’s journey on behalf of the client.

It should be noted that in more traditional shamanic cultures, the shaman usually makes the journey for the person in need, whereas in Western shamanism, an individual may conduct a journey for his or her own behalf. Hungaraian anthropologist Mihaly

\textsuperscript{20} A sacred brew historically used among indigenous groups in the Upper Amazon. It is made from the stem of the ayahuasca vine (\textit{Banisteriopsis caapi}, or in Quechua, “the vine of the ancestors”) and the leaves of either the chacruna (\textit{Psychotria viridis}) or chagropanga (\textit{Diplopterys cabrerana}) (Luna 2003:20–23).
Hoppal notes in his discussion of urban shamanism that “a fundamental change regarding the function of the shaman” is that “in olden times, he or she used to make the journeys, [but] now it is the participants who make them” (1992:204).

Michael Harner claims that about 90 percent of the world’s shamanic cultures use a monotonous percussive sound, or what he also refers to as “sonic driving” to enter altered states of consciousness, rather than “significant psychedelics.” [Also referred to as theogens, these are most commonly used in the Amazon and West Central Mexico.] The drumbeat is found to work best at 4-7 hertz which falls within the theta range of EEG waves (M. Harner 2005b:2).

Specific healing techniques of the shaman/shamanic healer include “extractions,” involving the removal of unwanted attached energies and “soul retrieval” to reintegrate aspects of an individual who has suffered from “soul loss” (a result of some trauma or tragedy). Such conditions may manifest in physical, emotional, or psychological conditions or illness. When an individual is overcome by another spirit, a healing ceremony of depossession may take place. Or when a person is about to die, “psychopomp” may be performed to assist the spirit of the dying—or already deceased individual—to “cross over.” “It is as a further result of [the shaman’s] ability to travel in the supernatural worlds and to see the superhuman beings (gods, demons, spirits of the dead, etc.) that the shaman has been able to contribute decisively to the knowledge of death” (Eliade 1964:509).

In traditional shamanism, the shaman often cloaks him or herself in ritualistic attire, unique to each individual. The shaman’s costume itself “constituted a religious cosmography” and disclosed “not only a sacred presence but also cosmic symbols and
metapsychic itineraries” (Eliade 1964:145). The shaman often might wear some sort of
tunic (made of animal skin or handwoven fabric) with various symbolic accoutrements
that dangled or glittered (e.g. copper mirrors), donning a mask (though more in the
Americas than Asia), and carrying paraphernalia such as a drum (oval in shape with a
head made out of animal skin), a bow, a rattle, a staff, feathers, or a bagful of amulets.
The shaman might appear in animal form, such as a bird, a reindeer (stag), or a bear
(Eliade 1964:145–180). However, in Western practices of shamanism, practitioners do
not necessarily don a costume.

Initiation

For an individual to be deemed a shaman in traditional societies, they must
experience some form of initiation. Eliade notes that in Central and Northeast Asia,
individuals may become shamans as a result of hereditary transmission or through
“spontaneous vocation” (1964:13). This may occur through events such as serious injury
or illness, being struck by lightening,\(^{21}\) or some sort of trauma. “What is clear from the
cross-cultural evidence is that the shamanic vocation often implies a crisis that simulates
the symptoms of madness. But one cannot become a shaman until one has resolved this
crisis” (Furst 1994:7). Eliade also mentions that there are cases of individuals choosing
to become shamans “of their own free will or by will of the clan” but these “self-made”
shamans “are considered less powerful than those who inherited the profession or who
obeyed the ‘call’ of the gods and spirits.” The initiate must also receive certain teachings
and may experience a public ritual of initiation or privately experience it in the dream-
state (1964:13). Other initiatory events may involve eating and drinking certain foods, or

\(^{21}\) See “Lightening Shamans” in Shamans, Healers, and Medicine Men 1992 by Holger
Kalweit (pp. 46-51).
fasting; living in isolation for a period of time, or embarking on a trek such as a “vision quest.” Or an initiate may incur a near-death experience; or dismemberment that involves the desecration and reformulation of his or her body while in a trance state, such as the ripping of flesh and crushing of bones followed by reconstruction into a new being. In traditional societies, whatever form of initiation was experienced, the process and continued training usually took many years.

**Shamanism and Western Medicine**

Not only is there a plethora of articles on the subject of shamanism in general, but more and more studies are being published on specific aspects of shamanic healing, such as its applicability to treating substance abuse.²² There are many more articles on shamanism and psychotherapy, than there are on shamanism and the treatment of organic medical conditions, but this may change with time. A book on shamanism in Western medicine edited by Barbara Tedlock is nearing publication that will discuss the role of shamanism in both arenas of health care. Studies measuring the efficacy of shamanic healing is somewhat difficult, but there are attempts at this. Sandra Harner, wife of Michael Harner, has conducted a number of studies to measure psychoimmunological effects (Harner and Tryon 1992; Harner and Tryon 1996a) and therapeutic effects (S. Harner 1995; S. Harner 1996; Harner and Tryon 1996b).

**Beginnings**

In June of 2002 in Santa Fe, New Mexico, the first annual conference on medical shamanism was held: “Ancient Healing Techniques: Integrating Shamanism into

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²² Shamanic approaches to substance abuse has also been studied (see Michael Winkelman’s website on ‘Substance Abuse Rehabilitation and Alternative Medicine” for a bibliography of “Additional Resources on Shamanic Approaches to Addiction” (http:www.public.asu.edu/~atmxw/subabuse.html).
Personal Life and Medical Practice.” Through the initiative of seven medical doctors and sponsorship by FSS and Innovision Communications, approximately one hundred attendees, mostly with medical backgrounds, gathered for five days to participate in facilitated experiential workshops and share their interests and/or experiences with shamanic practices (Brunton 2002; Foundation for Shamanic Studies 2002). The conference ran three consecutive years and then reformulated under the auspices of an outgrowth organization, the Society of Shamanic Practitioners (SSP). SSP has continued to sponsor an annual five-day conference offering experiential workshops on shamanism, and hosts a membership of over eight hundred practitioners and interested persons (as of October 2008), which includes many Western medical practitioners. [See Appendix M for SSP’s stated mission and vision; and “principles of integrity.”]

The seven founding medical practitioners as well as many of the facilitators and conference participants received their shamanic training, at least in part, from Michael Harner or FSS faculty who are students of Michael Harner. Thus the understanding and practice of Core Shamanism at these conferences is a common thread among participants, and these conferences have all required that participants have a basic training of shamanic journeying before attending. FSS continues to offer a number of shamanic training workshops, including its more advanced three-year program, reportedly offering 203 courses to approximately five thousand individuals annually. Applicants are required to take trainings in a series to build on developed skills over time. Besides training Westerners in shamanism and shamanic healing, FSS conducts cross-cultural research.

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23 The Society of Shamanic Practitioners (SSP) respects all shamanic traditions. It was formed in 2004 to help assist the re-emergence of shamanic principles and practice in modern society (http://www.shamansociety.org). [see Appendix M.]
and experimentation as well as scientific research on the health benefits of shamanic healing, sponsors programs to support the preservation and revival of indigenous shamanism, and produces a semi-annual journal *Shamanism*.

Other organizations that offer shamanic training programs in the United States and/or sponsor trips to communities to meet with traditional shamans (for any interested individuals) include The Center for Spirited Medicine; Down to Earth – The Shaman’s Circle; Dream Change; The Four Winds Society; Last Mask Center; Pachamama Alliance; Riverdrum; The Shunguan Center for Intercultural Studies; and Spirit Passages (though there are certainly many more, including many individuals who offer small, local workshops). Over time some of these organizations have shifted their directives based on their perceived needs of sharing shamanic principles. For instance, Dream Change, founded by author and activist, John Perkins, once sponsored a number of trips to take Westerners to meet with shamans in indigenous cultures; however Perkins now focuses on teaching large groups of people in the United States, stating that he felt more of a need “to reach out to people in this country and wake folks up” (personal interview).

**Theory of Consciousness**

Although a full discussion on the theory of consciousness is beyond the scope of this dissertation, it is worth mentioning general concepts as it plays an important role in the understanding and evaluation of the shamanic experience. Studies in psychology, philosophy, theology, religion, evolutionary biology, anthropology, and now even genetics have explored the subject of consciousness. The field of transpersonal psychology has expanded an understanding of altered states of consciousness, countering the psychiatric view “that altered states of consciousness are pathological, regressive, or
infantile[,]” but instead “more highly evolved forms of consciousness” (Winkleman 1993:3). However, even among transpersonalists, the notion of evolutionary hierarchy exists, postulating that so-deemed “primitive” practices such as shamanic journeying are less evolved precursors to more highly evolved contemplative practices such as Buddhist meditation (Winklemen 1993). Psychologist Timothy Hubbard (2002) discusses the correspondence of shamanism and contemporary cognitive science, highlighting the shamanic “web of life” worldview and the “attribution of intentionality to nonhuman elements of the natural world” that has often been viewed as fantastical or psychopathological from a Western scientific perspective.

Articles in the sub-discipline of the anthropology of consciousness have also addressed the socio–political perspectives on consciousness. Given the use and exploration of psychoactive drugs – and other consciousness altering activities such as shamanic drumming – in various cultures, “what happens to consciousness” under such conditions “is a question that anthropologists are increasingly being forced to confront” (Letcher 2007:74–75). Edith Turner (2006), a strong advocate of participatory fieldwork, notes that the shift from objective positivist approaches to studying spirituality to more first-hand experiential research is gaining ground. Her tabulation of AAA presentations on spirituality, healing, shamanism and the like finds that there has been an exponential increase in recent years – more publications on this topic from January to September 2006 than in all of the first half of the 20th century.

A recent analysis on the discourses of psychedelic drug use discusses Foucoults’s critique of societal evaluation of drug usage and the introduction of resistive discourses
such as reference to entheogens.\textsuperscript{24} Within “the dominant scientific–materialist–
deterministic discourse” [which I would argue includes the biomedical model of Western
medicine], the idea that “psychoactive drugs [which are comparable in this context to
other mind altering agents such as meditative drumming] elicit encounters with conscious
autonomous spirits or intelligences cannot be countenanced,” and “therefore must be
ridiculed as delusional” (Letcher 2007:77). Individuals who practice shamanic
journeying, even—\textit{especially}—persons with MDs, often confront this prevailing attitude
of the dominant culture. In my interviews and personal interactions with medical
professionals who stand with a foot in each discourse (i.e. the dominant Western
scientific paradigm and for instance, the “resistive entheogen discourse”), it makes for a
delicate balance. This is especially true when a person’s reputation, financial well-being,
and legal standing are at stake.

As well as the social sciences, there has also been an increase in the study of
consciousness in the biological sciences. The emerging science of “epigenetics” (which
literally means control above genetics) studies the influence of the environment,
nutrition, as well as stress and emotions, on gene replication and function. An aspect of
the field of epigenetics is the psychobiology of gene expression in which the
interconnected relationship of the genetic–emotional state (as well as hormonal
functioning, the immune system, etc.) is examined.\textsuperscript{25} As stated earlier, Jeremy Narby

\textsuperscript{24} A term that means “generating the experience of God within.” This neologism was
coined by classicist Carl A. P. Ruck at a meeting convened by Robert Gordon Wasson to
devise a new nonpejorative word for “hallucinogen” and “psychedelic” that referenced
psychoactive plants that induced profound religious experiences (Letcher 2007:84–85).

\textsuperscript{25} Recommended readings on this topic include: The Biology of Belief 2005 by Bruce H.
Lipton; Molecules of Emotion 1997 by Candace Pert; and The Psychobiology of Gene
provides a biologically-based hypothesis relating the shaman’s claim to communicate with animate essences, and Mircea Eliade’s numerous references to shamans’ visions of ladders and stairways to reach the Upper and Lower Worlds on their journeys— to the double helix construct of DNA. While some have argued that Narby’s thesis is still too scientifically materialist (personal interview with Jacques Mabit, MD and shamanic practitioner), Narby has attempted to move past the Western scientific paradigm that perceives nature as lacking consciousness.


This view upholds a belief in an objective world, independent of the contingency of its observers. It assumes that the data being analyzed within an experiment are independent of the preconceptions, perceptions, and the experience of the scientist analyzing them. . . . The problem is not with the empirical data of science but with the contention that these data alone constitute the legitimate ground for developing a comprehensive worldview or an adequate means for responding to the world’s problems (pp. 12–13).

The study of a movement to expand health care to include shamanic healing as an additional modality to biomedical approaches is ultimately a small group’s efforts, in part, to address a growing problem of inadequate health care in the United States, as well as changing perspectives in scientific awareness.

**Perspectives on Medicine**

Globalization refers to “new forms of integration and interdependence between the various parts of the globe” with “an intensified spatial and temporal dimension” referred to as “the compression of time and space” (Holton 2000:141). The consequences

*Expression: Neuroscience and Neurogenesis in Hypnosis and the Healing Arts* 2002 by Ernest Lawrence Rossi.
of globalization on culture have been scrutinized, revealing “an unresolved argument
between three basic positions: the homogenization thesis, in which globalization leads to
cultural convergence; the polarization thesis, which posits cultural wars between Western
globalization and its opponents; and finally, the hybridization, or syncretism, thesis in
which globalization encourages a blending of the diverse set of cultural repertoires made
available through cross-border exchange” (Holton 2000:141). While economics and
technology may be more apparent examples of homogenization, the world of art, religion,
and culture is less definitive. “We are clearly faced with the paradox that while global
economic, technological, and political change exhibit high levels of convergence around
market-driven capitalism, electronic technology, and liberal–democratic politics, culture
is characterized by high levels of divergence” (Holton 2000:151). I would thus argue that
the practice of shamanism in Western medicine is an interesting case of syncretism,
although it has its polarizing components.

Medical pluralism is commonplace throughout the world, especially within
modern industrial societies (Baer et al. 2003). Most societies offer more than one system
of healing, and the field of medical anthropology has explored medical pluralism and
syncretism in many cultures, often focusing on the bridging of Western (‘conventional’)
medicine with traditional practices. It has been argued that the common dichotomy

26 Although the term “syncretism” is rooted in religious practices, and often derogatorily
so in its contrast to a “pure” religious practice, the use of this term in anthropology has
evolved past this “purely” negative association. The term ”hybrid” also once carried
racist overtones, but is now used more neutrally, referring to aspects of globalization
(Stewart 1999).

27 Interestingly it is often referred to as “traditional” in both academic literature as well
as by medical practitioners. In this study I will reserve the term “traditional” for
representation of earlier modalities borne out of indigenous cultures.
blazed between these two systems is not absolute (Stoner 1984); however, in the case of biomedicine and shamanic healing, there are many important contrasts, which in part is what makes this study especially interesting. Although the United States can be characterized as medically pluralistic, especially given the large population of immigrants, it should be emphasized that this study extends beyond simply examining the practice of shamanic techniques in a country whose dominant health care system is steeped in a biomedical model. What makes the subject of this study syncretic is that it is not merely about the existence of two differing practices side-by-side, but the integration of them, via individual practitioners as well as a collaborative approach at a particular health center.

Within this investigation, the reader might tend to think of shamanism as an addendum or insert to the broader framework of Western medicine – yet some argue it is actually the opposite alignment. Dr. Donald Warne, MD MPH and member of the Oglala Lakota tribe views his work as the incorporation of modern medicine into traditional practice “because modern medicine is focused primarily on the physical realm” while the Lakota way defines health as a balance of the “spiritual, mental, physical, and emotional realms.” “Physical is a component, but it’s only one component among four” (Horrigan 2005:125). Shamanism includes these four aspects of health and furthermore, operates in NOR as well as OR, while Western medicine functions strictly within the latter (for there is no formal recognition of NOR in theories of Western medicine). However, we need to remain cognizant of basic concepts of CMA in which power relations is a key

28 Other suggested readings of Native Americans who have received medical degrees and then attempted to combine their native healing traditions with Western medicine include *The Scalpel and the Silver Bear* 1999 by Lori Arviso Alvord, MD and Elizabeth Cohen Van Pelt; and *Coyote Medicine* 1997 by Lewis Mehl-Madrona, MD.

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aspect of examining health and health care. Although shamanism may hold a more expansive view of what it means to be healthy, the biomedical paradigm and the economic, bureaucratic, and social forces that adhere to it administer a broader governance over the practice of shamanic healing in institutionalized medicine in the United States.

**Conclusion**

The study of shamanism over the past centuries has portrayed the role of shamans in varying shades of dark to light, demon to heroic healer, often questioning the very meaning of the term itself. And like the noble–savage iconography of Native Americans and other indigenous peoples that materialized as their populations began to dwindle, a similar identification has emerged with the recognition of traditional shamans dying out. Yet as a result, Westerners have been drawn to the practice of shamanism to fill voids where Western medicine has failed to address physical and psychological conditions, as well as to train in shamanic techniques for personal healing and sometimes for professional application. This movement has resulted in the revival of shamanism that includes efforts to support traditional shamans in their native communities—but also to spawn a new form of shamanism as it is adopted and adapted into a different cultural context than its precursors. The biomedical paradigm is the new cultural backdrop for this study.

Some traditionalists might argue that the ensuing described practice of shamanic healing is not truly ‘shamanism’ because of its new cultural backdrop that is removed from the cultural particularity out of which the term was first coined. Mihaly Hoppal’s discussion on urban shamanism raises this question near the closing of his essay: “Is it
shamanism, in the proper sense, at all?” But he quickly answers: “both the forms and the authentic cultural contexts have changed; but, for all that, the social function of the entire complex of phenomenon does function, its internal meaning exercises an influence on the individual and the community alike” (1992:208). Furthermore, the fact of the matter is that urban/core/neo-shamanism is a cultural movement unto itself, and thus worth studying, regardless of its nomenclature. As one anthropologist concluded in his struggle to validate the authenticity of shamanism upon its contact with ‘New Agers,’ “an obsession with the ‘traditional’ obfuscates the actual dynamic quality of culture” (Joralemon 1990:117).

And within the movement of combining shamanic practices with Western medicine, there is more to this syncretic effort than mere “navel gazing” as some might describe New Age activities. Mircea Eliade described shamans of traditional societies as the “pre-eminent … antidemonic champions” who combated demons, disease, and black magicians” (1964:508). The shamanic practitioners in Western medicine today are attempting to overcome the “soul loss” of biomedicine that emphasizes a strictly biological and technological approach to health care, through attention and practice of “soul-level” care.²⁹

²⁹ Cecile Carson, MD in her unpublished article “Shamanism at Work: Expanding the Clinical Mind” (January, 2006) describes the movement of “transpersonal medicine” which is a set of therapeutic approaches that emphasizes soul-level care, with shamanism being its most ancient form.
A young adult woman lies in a hospital bed with severe back pain. The doctor reports to her that she has a tumor in her spinal canal and that it needs to be removed immediately; even another day’s delay could cause serious complications. But her parents walk in and the patient’s father says that she cannot have the operation and must be released from the hospital right away. Through later conversations with the daughter and father, the doctors learn that the family is Hmong and their traditional belief system is spiritually-based; and that the daughter’s illness is due to “a lost soul” that needs to be retrieved by a shaman before an operation can be performed. The doctor tells the father that they will have to get a shaman – today – upon which the father retorts, “Shamans aren’t listed in the ‘Yellow Pages’. My shaman lives 500 miles away.” The doctor offers to helicopter the shaman in to the hospital which is what happens. Dressed in traditional garb, waving a lit smudge stick, the shaman performs a healing ceremony in the hospital room with the attending doctors looking on. At a certain point the patient gives one of the doctors a nod, denoting that her missing soul has returned. And soon after the patient is rushed on a gurney into the operating room. Later in the program we hear that the operation was successful and she is going to be fine. [“Bring the Pain” Episode 5 of Season 2 of ABC’s Grey’s Anatomy, originally aired Oct. 23, 2005]

Firstly it is interesting to see that the role of shamanism in the United States has finally made it onto broadcast television, a top ABC primetime drama at that. The storyline is about an immigrant Hmong family, an ethnic group whose recent population in the United States has grown exorbitantly. As the U.S. population continues to grow, significantly due to immigration, various traditional rituals and practices from around the globe are making their way into the cultural matrix of the United States. And given that some form of shamanism is or was practiced by most non-Western cultures, it is no

30 The 2000 U.S. Census reports an 88% increase in self-identified Hmong living in the United States between the years 1990 (a reported 90,082) and 2000 (a reported 169,428).
surprise that forms of shamanic practices in the many immigrant ethnic pockets of the United States take place, and thus are seeping into the edges of mainstream culture.

Secondly, as has been discussed in previous chapters, the practice of shamanism has made its way into mainstream U.S. culture by an undercurrent of various practicing American-trained shamanic practitioners, including those with medical degrees. Thus if a patient in a hospital requests a shamanic healing, they may not necessarily have to helicopter in a shamanic healer from 500 miles away (unless they have a need for a particular individual) and in the not too distant future they actually might be able to look in the ‘Yellow Pages’ for the nearest local shamanic practitioner – or simply call in a residing RN or MD for an extraction or soul retrieval.

This chapter presents research regarding Western-trained medical practitioners who have studied and in most cases, are also practicing some form of shamanic healing. The information and quotes relayed here are compiled from survey responses and follow-up in-depth interviews with twenty-seven practitioners. The group of practitioners interviewed represent those working in seventeen different states (no more than three per any one state), and a range of clinical settings including hospitals, government-funded health services, private group practices, solo practices, nursing homes, and hospices. Ten of the interviewees are male; seventeen are female. Some are general practitioners while others specialize in internal medicine, pediatrics, geriatrics, psychiatry, rehabilitation, palliative care, plastic surgery, and neurology, as well as osteopathy, dentistry, and pharmacology. Some respondents work full-time as health care providers while others also serve as faculty in teaching hospitals and/or as managerial administrators. Many practitioners work with clientele from the general populace, but some specialize in
immigrants, trauma patients, the mentally challenged, or prisoner populations. Some practice covertly, and some overtly; some also have a separate shamanic healing practice on the side. Shamanism means different things to different people, although the overall ideology appears to reflect a commonality and confluence of attitudes about the process of healing and the role of the healer. However, the reader will discover that the means by which individual practitioners use their shamanic training and incorporate it into their medical practice varies almost as greatly as the number of individuals interviewed.

Furthermore, at this point in time, either due to the relative rarity of this practice, or the lack of full-scale acceptance by the medical community and public at large—or possibly due to the vary nature of shamanism—most practitioners who walk the line between the biomedical model and shamanic practices do so in solo fashion. The traditional shaman of indigenous communities usually lived on the edge of their community, both geographically and socially. At this point in time, it appears that many shamanic healers in the United States also sit peripherally at the edges of the medical community. But with growing dissatisfaction of present-day health care by the providers as well as consumers, the incorporation of shamanic healing techniques may someday come to situate itself more centrally.

During interviews with practitioners, I attempted to draw out their interest in shamanism, their training, its meaning, and from there discuss how they have adopted it into their medical practice, or where they have felt challenged to do so. These general topics have been broken down into a number of more detailed categories of discussion outlined below. Information and opinions obtained from an additional six interviews of
high-profiled individuals involved in shamanic practice, training, and/or advocacy

provides some further perspectives on this chapter’s discussion.

**The Beginnings**

Many of the practitioners began their foray into medicine through Western medical training, following a prescribed biomedical approach until later events somehow drew them into an alternative world of understanding illness and healing. A number of respondents recounted stories of coming across a particular workshop flyer or book that somehow ignited a curiosity to delve further:

* A practitioner’s son was reading Michael Harner’s *The Way of the Shaman* for a high school class and so she decided to read it too. Soon after she signed up for the FSS Basic Workshop (Denise, RN).

* “I first became interested in shamanism when my partner shared a few books with me on the subject. I’ve always been looking for an alternative way of working at the bedside and finding that the Western model just did not meet the needs of the whole patient; I always felt there was something lacking” (Elisa, RN).

Some relayed especially serendipitous stories of their entry into shamanism:

* One MD told of how she got a call one night, many years ago, from an organization that sponsored personal development-type programs, where she had taught courses in physiology to prospective massage therapy students. She was asked if she could host a presenter who needed accommodations, and in return she could attend the presenter’s workshop for free. The presenter turned out to be Michael Harner who was leading a basic workshop on shamanic healing. She felt chills listening to Michael give his opening talk on Friday night and “knew” she needed to be doing shamanic work. “When Michael started talking, after about ten minutes, it was like ‘I’m suppose to be doing this’ and thought ‘where has this been all my life, you know, this is the missing piece.’” She went on to take all of Michael’s workshops, including his three-year apprenticeship (Dora, MD).

* One interviewee opted to get an MD rather than a DO or doctor of naturopathic medicine because she felt a need to expand allopathic medicine. “I had visions since I was 16; walking on the spiritual side is not strange to me.” However, she attended her first workshop on shamanism by accident when she sat in on a workshop led by Sandra Ingerman instead of the session on nutrition that she had meant to attend. She then quipped, “But there are no accidents” (Carmen, MD).
Many began their exploration into shamanism for personal development or to deal with a personal issue:

* A pediatrician noted that she was first drawn to shamanic healing for personal work, but as she continued to take more and more workshops, in a three-year FSS apprenticeship program, there were three physicians among the 65 participants which got her thinking about how she might use it in her medical practice as well (Dina, MD).

* A rehabilitation physician first experienced shamanic healing about six to seven years ago to address some emotional issues going on at the time. He found shamanic healing worked more on a heart and spiritual level rather than through a cerebral therapy-based approach and so soon after decided to use it in his medical work (Bert, MD).

* A psychiatrist went to a holotropic breathing workshop where she had some powerful experiences. A member of the group recommended she might want to check out shamanism, specifically FSS, so she signed up for her first workshop in shamanism through FSS. “I took to [shamanism] like a fish to water” (Tanya, MD).

* A neurosurgeon’s interest in shamanic healing began around the age of fifty. He went to a therapist to seek counseling for major depression. The therapist suggested he see an astrologer who told him he had healing abilities by being near a patient rather than operating on them, and should check out shamanism. He didn’t follow-up right away, but while at a Jungian conference, “heard the ‘s’ word again” and a reference to Michael Harner. So he decided to read Harner’s books and others, and then sought out a personal shamanic healing. His personal experience validated shamanic healing for him and he soon began taking workshops on it (Roland, MD).

* One practitioner felt she was missing something in her own life, and also saw patients returning with the same problems over and over again. She went to see a shiatsu massage therapist at which point she began having dreams that she shared with her therapist. The therapist encouraged her to have a conversation with one of the beings in her dream who told her that she should go see a shaman. She had recently seen an Omega catalogue and although she didn’t know what a lot of the workshops were about, she felt drawn to them. So after working with her dreams, she went to Omega to meet with a shaman, and from that point on, she was “hooked” (Ellen, PA).

* An osteopath first discovered his own healing abilities while vacationing in Fiji where he developed stomach problems. He stated that each Fijian family specializes in a specific part of the body, so the community called in a stomach
specialist who practiced a form of “healing touch.” He quickly became well and then began practicing the technique himself, followed by various shamanic healing trainings. He has returned to this remote Fijian village many times where he reports they still live a traditional lifestyle and practice Fijian medicine (Stan, DO).

Others discovered a gift for shamanic/spiritual healing while working with a client:

* An osteopath relayed how he was working on a female patient’s shoulder and suddenly he and she both went into a trance and he saw a scene of her being raped. It turned out this was the cause of her shoulder problem. This led him to try some workshops in shamanism (Tim, DO).

Shamanic training for my interviewees varied extensively. Some learned predominantly from one individual teacher, while others attended various workshops and apprenticeships with different teachers. Many of the teachers are Westerners who are affiliated with the Foundation for Shamanic Studies (FSS), and often first-generation students of Michael Harner, Ph.D and a Shuar-initiated shaman. Other cited teachers who are well-known Western shamanic practitioners include Eliot Cowan, Tom Cowan, Myron Eshowsky, Sandra Harner, Allie Knowlton, Sandra Ingerman, John Perkins, Larry Peters, Christina Pratt, Evelyn Rysdyk, and Hank Wesselman. Many of the practitioners interviewed also received some of their training by traditional shamans, either in the United States or the shaman’s native country. Teachers representative of specific tribes such as Aborigine, Atis (Kichwa), Cocama, Fijian, Hopi, Huichol, Inka, Ojibway, Shuar (Jivaro), Tibetan, Tuvan, Ulchi, Yaki, and Zuni were mentioned in survey responses or personal interviews, as well as by country, including Brazil, Ecuador, Mexico, Peru, and Russia. However, almost every interviewee noted that they did not practice within any one tradition, but took aspects of many practices to develop their own unique style; or as
with the case in FSS trainings, students trained in Core Shamanism, which emphasizes the fundamental commonalities of differing shamanic traditions.

**Personal Meanings**

As discussed in chapter 3, there are many differing applied definitions of shamanism. In my interviews, I included a question probing the more personal definition attributed to shamanism.

A common denominator in many responses was the notion of “connection” and the transgression beyond separateness:

* “It’s about deep connection to spirit, meaning every aspect of life and death and different worlds, upper, middle, lower. Everything is connected, everything is one. And it means to be in service to others” (Neal, DO).

* It is “planetary, it goes beyond our immediate body . . . And the more mass of folks we get doing their own personal work, the higher the spiritual level of the whole country, the whole world” (Kayla, DDS).

* “A shamanic worldview is a view in which we as a culture realize that we are all connected, that the way we live our lives affects the way every other person, every other being, and the entire planet functions. We’re acting as if we are not connected in that whatever I do, I do in isolation. A shamanic worldview says ‘no, no, no, this will never work’. Not only do we have to think about how our actions affect everything on our planet, but it also says that the way we think has an effect. And our connection with something beyond ourselves is important too and has meaning and adds a component to our life that is innate to who we are beyond just the body” (Bert, MD).

Another interviewee described it in terms of motivation:

* “You need to think about shamanism as an exercise in power. In T.S. Eliot’s ‘Murder in the Cathedral,’ the knights tempt Thomas Moore who then says ‘The last temptation is the greatest treason. To do the right deed for the wrong reason’. My view of shamanic power is that the discipline and the work is about learning to do the right deeds for the right reasons” (Carl, MD).

Some interviewees clearly held a specific understanding of shamanism as a defined practice, while some discussed it in broader, more generic terms:
* Shamanism is “spiritual healing, healing with God, healing on another dimension than the physical.” This interviewee interchanged the practice of shamanism with other spiritually-oriented healing techniques, such as healing touch (Stan, DO).

Other interviewees described shamanism in contrast to Western notions:

* There is no perception of the body–mind dualism in shamanism as there is in Western medicine, based on the theories of French rationalists, such as Rene Descartes. “Our collective culture is ego-driven whereas shamanism is soul-driven” (Lewis, MD).

It is also important to highlight how the study of shamanism shifted people’s perceptions of and experiences with the world around them. Some practitioners spoke of paranormal experiences in their youth that often they and those around them did not understand:

* Referring to her spiritual experiences since age sixteen, which she did not understand at the time, “shamanism is what organized it for me, defined it for me” (Carmen, MD).

* “I had certain things happen to me as a kid that I didn’t understand at the time, but might understand now. For instance, being contacted by spirits” (Denise, RN).

For many, it allowed for what might be described as an expanded understanding of existence . . . :

* Since studying shamanism, “I think I have more of an openness to seeing the extraordinary in life. I look at my world much more as the ‘middle world’ and not really just the only world” (Urma, MD).

or a source of comfort and support:

* “It helps me feel much less afraid about what’s going on in the world. I’m much less afraid of dying now than I was ten years ago. … I also have a better sense of my purpose here” (Ellen, PA).

* “There’s so much available in the spirit world for healing. All you need to do is ask and have some discipline to bring it in. There’s so much powerful healing available. It’s almost mind-boggling to me. It’s for all humanity. There’s a core
shamanism through virtually every culture. And I find that comforting (Elaine, RN).

The study of shamanism has offered a deepening of existing or new relationships through the practice, or through collegial connections:

* The study of shamanism has “opened me up a lot more to the natural world and my family.” This interviewee stated that he always loved spending time outdoors, but now feels he has a closer association with nature and participates more in environmental activism. (Everett, MD).

* One practitioner has facilitated a drumming/healing circle for 25 years and hosted sweatlodges in her backyard for 22. She also joined with six other physicians to initiate an annual conference, “Shamanism in Medicine” that ran for three years from 2002-2004. “Through my shamanic practice, I met and connected with a lot of special people” (Dora, MD).

However, practicing shamanism can also cause an individual to feel alone and isolated (with respect to humans) and out of sync with people around them:

* Married to an evangelical Christian, a practitioner confided in me that he has struggled in his marriage since he began practicing shamanism. His wife believes he’s “in bed with the devil” (Sam, PA).

* “Because I’m not really focused on material things and my reality appears different [to that of] the average person, it’s difficult for some people to understand and accept my approach to life” (Nina, RN).

Specific to their medical practice, shamanism has offered new perspectives on their role as a practitioner and in some cases, new directions:

* “Shamanism has made me notice more and trust my own form of nursing and method of healing” (Elisa, RN).

* A practitioner stated that she feels isolated in her medical field with respect to her shamanic work, but added that she has followed a divined path for the last fifteen years. “I am blazing a trail. If I were to have waited for someone else to have done this, I would have waited ‘til hell froze over”’ (Kayla, DDS).

* Shamanism has allowed for “more focus on my goals of what I need to be doing with my life. I have my power animals and a medicine woman who help me. I also realize that my medical profession is holding me back. I think more can be
done for healing using shamanism and other alternative healing than what the medical profession can provide right now” (Nina, RN).

* A psychiatrist recently left her medical practice to study shamanism with a Yaki teacher, also moving out of state where she had found few doctors who were open to shamanic healing. She questioned whether she would return to a medical practice and was exploring ways to combine shamanic healing and psychiatry in a new manner with the expressed goal “to help people heal, to help people who are suffering. It’s both an inward and an outward process and it’s healing me at the same time” (Tanya, MD).

**Initiation**

The journey started with my power animals taking me to the street outside the hospital where I practice internal medicine and cardiology . . . I found myself in a dark room with four walls. There were four nuns sitting at a four-sided table . . . The nuns rose up from the table brandishing large hatchets in their hands. My first thought was how I was so not up for dismemberment. Instead, however, I began to see the nuns in the hallways of my hospital cutting off the hands and heads of the doctors and nurses. Once I saw a nun reach into the chest of a physician and rip out his heart . . . I realized the nuns were showing me how the medical staff was taking a very mental approach to patient care and working from an utterly mechanical and non-heart-based place. This was the wounding they found horrifying, the singular cookbook/medical protocol approach to patient care, lacking heart and soul. My attention was then drawn to the floor where I saw a gray skull, a pair of hands and a ‘river-jack’ [a smooth round rock found in riverbeds], laid out in proper anatomical spacing. Then I realized the ‘river-jacks’ were hearts and that I was suppose to lie down over the anatomical set-up and re-energize them with all the heart energy I could channel. After doing this, I thought I was done when my spirit guides stepped in and asked me to integrate a whole other energetic model. I agreed. As I allowed this new energy to flow into my body, I realized it was moving through every cell, into my DNA, and felt a structural shift in my energy field. I was pure light energy, floating, unable to feel my body . . . One of the nuns was standing over me and told me that the energetic model I had just integrated was the archetype of the healer and would I please carry this energy as I moved about the hospital. I didn’t have to do anything except hold the intention of being with the energy and allowing it to flow into the environment. I agreed. She told me not to tell anyone about this. She didn’t want my credibility to be compromised with the hospital staff. She told me not to look for outcome. This suggestion was actually very helpful because it took my ego out of the picture. The scene dissolved. I came back to my space on the floor in the workshop and offered thanks to my guides and animals and realized I was so excited to be doing this task (Ellen, PA).
In my interviews I asked practitioners if they experienced any kind of initiation, though I did not define it, rather allowing interviewees to interpret the meaning relative to their own understanding and experience. The above description was the most detailed response that I received. The majority of interviewees stated they did not experience one particular moment of initiation, or they were not sure whether specific experiences actually qualified as an initiation. Others felt they went through an extended process that may have culminated in a state of initiation:

* When asked if she ever had an initiation, she replied “Not a typical struck by lightening or illness” but went on to say that following a two-week intensive shamanic training, she experienced “a few difficult years,” that involved divorce, remarrying her ex-husband, and other turbulence (Elaine, RN).

* A practitioner feels she was initiated over time during a series of dreams in which she was “placed on a rock slab and her charkras were worked on with metal objects.” Although she felt no pain in these dreams, she usually felt ill for a period of 36 to 72 hours afterwards, accruing this to a form of cleansing “because you have to break down the resistance before the spirit of the soul can receive.” After recovering from the dream’s effects, she felt quantumly different, “bigger” and “lighter” (Emma, DMD).

* “While in a journey I received luminous seeds of healing to the groin area” but added that he is not sure whether this resulted in the instant conferment of powers. Although he may not have experienced one explicit moment of initiation, he engaged in a long process of personal healing and “clearing his body” so that he could embody spirit. He expressed concern that some practitioners “go ahead of their medicine” and quoted a Hopi saying, ‘Always walk behind your medicine.’ He added that that there are a number of ways to become a shaman, including self-initiation, but “just because you’re drawn to it doesn’t mean you’re meant to practice it” (Neal, DO).

**Incorporation into a Health Care Practice**

“We need to realize not all medicine comes through a pill or scalpel, but healing can be just as powerful through someone’s hands or voice” (Neal, DO).
Why and When

Exploring the practitioner’s adoption of shamanic healing into one’s health care practice includes understanding his or her perspective on its role in medical treatment, and when its application may be deemed appropriate or beneficial. Although determining the physiological efficacy of shamanic healing is beyond the scope of this study (and has not been explicitly measured in any study to date), it is important to understand how practitioners view its practice in terms of organic (i.e. physiological/biological) versus non-organic (emotional/spiritual) application. Ultimately, most practitioners discussed these two categories as connected aspects of physical ailments, but in most conversations, the practitioner alluded to the use of shamanic techniques for diagnostic purposes and psychospiritual support:

* A DO stated that “osteopathic manipulation works, but it doesn’t work as a technician [sic] which is the way it’s taught.” He feels that most DOs and MDs are practicing as technicians, and while this works in crisis conditions, it does not address spiritual problems which he believes is what most people suffer from. “Virtually everybody has a wound at the level of spirit, and that’s what most MDs, DOs, and other practitioners aren’t addressing, so the integration of osteopathic manipulation with spiritual healing is needed” (Neal, DO).

* When I asked one physician about using shamanic healing to address physical issues, he said that it was possible, but “it’s a blended process.” “Does shamanic healing cure stroke?” Well, not that I can see. ‘Does it facilitate a person’s recovery from stroke?’ Yes. In lots of different ways. In many ways, addressing the spiritual aspect of an illness helps to answer the question: ‘What does this illness mean to me and is there anything good to get out of it?’ For my patients, the physical, emotional, and spiritual are all connected. You need everything you’ve got to get home after a stroke” (Bert, MD).

* One MD says she uses shamanic work in her practice, but it depends on what she is doing with the patient at the time. “When I’m working with autistic kids and the parents are there and there’s a lot of medical data, I don’t [use shamanic techniques] because I don’t want to add another dimension into the lives of these folks which are already so difficult.” “When you’re in the middle of a pelvic exam, you’re not going ‘Ok, now what power animal is involved in this?’ or ‘Is there soul loss here?’” But the practitioner noted that when she is talking to a
patient, then sometimes she can work a shamanic technique into the treatment (Dora, MD).

An MD stated that he does not regularly integrate shamanic work into his health care profession given that he feels it is more appropriate for primary care, rather than his specialty in muscular–skeletal and occupational injuries (Carl, MD). However, another physician finds extraction work beneficial to easing pain from muscular–skeletal conditions (Bert, MD).

**Paraphernalia**

Physical environment, dress, and tools are another question that I explored with practitioners. In most cases, practitioners maintain a conventional outward appearance. They do not detail their professional health care offices, or themselves, with shamanic-related adornments, and stated they did not use any shamanic tools such as rattles and drums; however, there were a few noted exceptions:

* An osteopath describes his office as “nonconventional,” with a healing altar, casual dress, and sometimes the playing of “weird” music, but “not way out” as he does not use a drum or rattle (Tim, DO).

* One practitioner stated that to her knowledge, most Western health care practitioners trained in shamanic healing do not use native props such as rattles and feathers, rather they use “only [their] body for an instrument.” She goes on to describe her own experience. “By using three or four different traditions, I realize it’s not the trappings that are the important part, it’s not the rattle, it’s not the didgeridoo, it’s not the conventions of whatever they use culturally to move them into that trance state. It doesn’t matter which culture it is, they all have a different form of moving themselves into trance state, but once you’ve learned how to do it, you don’t have to have the objects to make it happen.”

  She also noted that her dentist office includes two therapy rooms in which to conduct talk therapy or body work on a massage table, but they are designed in a professionally conservative manner (Kayla, DDS).

* A nurse said that she has mentioned to patients that she practices shamanic healing, and that residents tend to know there is something different about her because she wears “native-styled jewelry, feather earrings, crystals, and bones.”
She added that “some are receptive and responsive to it, and others think it’s bizarre and strange” (Nina, RN).

* A physician who works at a University hospital stated that “Everybody seems to be pretty accepting to the degree where I’m banging my drum and everybody on the whole floor can hear it and it’s ok” (Bert, MD).

**Getting Started**

Getting started can be especially difficult for practitioners who were trained and then practiced within a strictly biomedical model. Here are two accounts of a practitioner’s first experiences with incorporating shamanic healing into their professional practice:

* A long-time practicing physician and shamanic practitioner says she still has trouble sometimes figuring out how to integrate the two. The key to it is having the confidence to talk to her patients about it, which she noted took a number of years. “I was doing healing work in the circle and I was doing medicine in my practice and trying to find a way to put them together, and it was just one of those things where at some point a patient would say something where it was so apparent that shamanic healing could be really helpful here.” She added that her next step is to check in with her guides to ask whether it is appropriate to act on her hunch (Dora, MD).

* An MD recounted her first clearcut example of using shamanic healing with a patient. A patient arrived who had suffered pelvic pain for two years, and after extensive medical assessments, was told ‘it was all in her head.’ The MD asked if she could try shamanic work and was guided to ask the patient about her family. The patient relayed information that signaled unresolved anger toward her mother, so the MD advised the patient to seek counseling to address the anger, which she did, and within two months, the patient reportedly was pain-free. “This provided an affirmation to me to continue using shamanic healing in my work” (Carmen, MD).

**Putting it into “Practice”**

Below are descriptions of how practitioners incorporate shamanic healing into their Western practice. Some strictly do so covertly, for various reasons that will be discussed in more detail in a later section, while others are very open with their shamanic work; and still others revert back and forth depending on the individual patient:
* An MD stated that he sometimes goes into a hypnotic state at will to do diagnostics, but uses an allopathic approach for the healing treatment. He also uses some of the basic concepts to encourage patients to talk about their feelings and express themselves. “I’ve found that everybody has issues with something about their past which in shamanic terms has probably caused soul loss. It takes extra time, but I try to squeeze it in when I can” (Everett, MD).

* As part of her shamanic practice, a dentist often uses energetic techniques to soothe patients with anxiety or fear of dental work, such as “running” energy through a patient by massaging their head after administering a shot of novocaine. Sometimes she does this covertly where patients feel they are getting a massage and other times overtly as they know she does energy work, even asking for special treatment to address their medical needs. Although she is trained in the practice of diagnostic journeying, she no longer needs to go through this process as she finds she receives “immediate hits” as soon as she puts her hands on a patient. She does not advertise her shamanic healing practices, but often receives patients by word of mouth or finds that patients with shamanic training “pick up” on her covert practice (Kayla, DDS).

* One practitioner told me he has two business cards, one for his medical practice and one for his shamanic healing practice, although he often combines the two healing approaches (Neal, DO).

* A physician assistant who works in a hospital said that she did not talk about her shamanic work with most of the staff, but that there were a few specific physicians with whom she could share her insights. She told of an event where a woman went into cardiac arrest in her hospital room. The Code team arrived along with a doctor. The practitioner could see the patient had left her body and was hovering in the corner. She asked the patient whether she wanted to return to her body or pass on, but the patient could not decide. The practitioner called the doctor out into the hallway and explained the situation. He took her account seriously and asked what course of action should be taken. The PA responded that given the patient’s indecision, he should continue with life support efforts. At one point the patient was trying to return to her body through her head, but was obstructed by the paramedics who were trying to push a tracheal tube down the patient’s throat. Finally the patient was able to return to her body and became stabilized (Ellen, PA).

The majority of the practitioners that I interviewed relayed a need for a large degree of discretion in their use of shamanic healing in their professional practice, but a few interviewees expressed a more extensive degree of comfort and openness:

* A physician working in a rehabilitation university hospital reported that he can “be fairly open” about his shamanic work. If he feels a patient is in need of
healing at the spiritual level, he might say to them, ‘I do spiritual healing in addition to my regular work as a physician and there seems to be a spiritual component to your illness that could be integrated into your treatment plan.’ If the patient is comfortable exploring this further, then the physician asks with whom they would like to work, suggesting clergy, a close friend, or himself. The physician will then explain the healing process, and then do a diagnostic journey in which he first asks his guides if he is the appropriate person to do the healing, and if so, what is needed. Sometimes he wears headphones to listen to a drumming tape or sometimes he sits quietly. The physician might explain the shamanic conditions of attachments or soul loss to a patient as an experience in which ‘you have experienced a loss of power or part of your life force has gone adrift due to this trauma’. Since the physician sees the patient every day for an extended period, this conversation usually takes place over a matter of days (Bert, MD).

* A nurse who provides services to nursing homes has found that many of the elderly are open to shamanic healing and has been able to approach them directly. She cited an example of one gentleman who was cognitively intact, but had suffered severe physical impairment due to a stroke. She has been talking with him about journeying and power animals—and is working up to soul retrieval—“to help him regain a sense of power and control over an aspect of his life” (Rachael, RN).

* An intriguing coupling of shamanic healing and Western medicine is practiced by plastic surgeon, Dr. Eve Bruce. Although the superficiality of physical appearance might seem contrary to the deeper spiritual principles of shamanism, Dr. Bruce points out that “modification of the body’s flesh and body adornment is hardly a Western practice; it’s very shamanic, very indigenous, and very old.” Because of the publication of her book, she is able to openly discuss her use of shamanic healing in her medical practice. She overtly works in shamanic techniques with her patients, such as journeying, although she noted with every patient she begins by asking them “their story” as a way of understanding their concerns and needs. “‘Story’ is very important in almost every shamanic culture, so [my consultations] start out with ‘Why are you here?’ followed by active listening. And yes, during active listening, I’m asking for guidance.” She added that when she first started practicing shamanic work with clients, she assumed that they would then choose not to go forward with surgery, but found that was not always the case. But the difference is that these clients approach plastic surgery with greater understanding, “so that it becomes a rite of passage.” She noted that most shamanic cultures include(d) some kind of initiation that often involve(d) bodily adornment, body piercing, or other external marking signifying change 31 (personal interview).

31 There are three stages in initiation ceremonies: (1) “separation” involving ritual removal of the individual from family and community; (2) “transition” that may include isolation and/or meeting a challenge; and (3) “incorporation” which is the formal return
* An osteopath claims he overtly journeys with his clients by either incorporating the client into the journey, or journeying back to the point of wellness in the client as a way to understand the condition from that point on. He adds that it is important to “carry the healing into present physical reality” and not simply heal the patient in nonordinary reality (Tim, DO).

**Putting it into Words**

For those who practice overtly or reference a non-conventional method of healing, their chosen discourse, such as selected phrasing and terminology, is of interest. Excerpts below provide examples of how a practitioner explicitly introduces and/or offers shamanic healing to his or her patients. All my interviewees expressed a strong degree of thought and concern as to how to broach the topic with their patients, and how to put it into context. One practitioner says that she has used the term “shamanism” from time to time, prefacing that it is an ancient healing technique and is even listed in the *Index Medicus* (Elisa, RN). However, most stated that they circumvent this term, even when referring to a specific shamanic healing approach:

* In one case, a practitioner had a patient who was fixated on a spirit possession for years after stumbling upon a corpse in a walkway. Conventional modalities of treatment were not helping, so the physician discussed the idea that some cultures believed in spirits and performed ceremonies to send the spirit on to the next world, but avoided the word ‘shamanism’. The practitioner offered to perform a ceremony at home for the patient, making it clear that she would not perform such a ceremony in her workplace. The interviewee concluded the account stating that the patient agreed and she conducted the ceremony at home as offered. After that point, the patient’s concerns appeared to be alleviated (Linda, MD).

* A practitioner who works in a Mormon-managed hospital suggested holding a prayer circle for a patient who “was very fractured,” noting that in the Mormon culture, communities often practice prayer circles. The patient agreed and it was found to be effective. The practitioner said she described the ritual as similar to asking spirits for a soul retrieval. Yet, “if I had used the word ‘shamanic,’ she’d have stopped listening to me. So it’s how I present it. ‘Does that make me

and readmission back into the community in his or her new status (Van Gennep, Arnold. 1960. *The Rites of Passage*. Chicago: University of Chicago Press.).
dishonest?’ (asked rhetorically) No. It just has to do with what language you’re speaking. And in many ways we’re speaking the same language, it’s just the choice of words you use” (Carmen, MD).

* An osteopath describes his techniques to patients (and in his brochures) using phrases such as “spiritual medicine” and “holistic medicine.” He notes that when dealing with the public, it is important to use terms that are familiar, and he feels ‘holistic’ is now accepted. “It’s not a turn-off to the public. In fact, they’re seeking holistic care.” He described the evolutionary process of terminology, beginning with ‘alternative’ in 1993, then ‘complementary’ to ‘CAM’ and now ‘integrative’. He views this evolutionary process as a way to facilitate the emergence of shamanic healing within “a vehicle that is now being accepted (i.e. Western medicine), rather than a stand-alone practice . . . The American public still looks to physicians as the top of the health care pyramid. So I think [the validation of shamanic healing] needs to come from within a medical framework” (Stan, DO).

The quotes below reflect a much more reserved and discretionary approach to discussing and practicing shamanic healing:

* “I do it under the radar” is how one practitioner described her covert practice of shamanism. She does this through journeying (without the use of any props), story-telling, healing by conscious intent, and enhanced diagnostic intuition (Linda, MD).

* A pediatrician stated she is not that comfortable using shamanism in her medical practice because her partners are not comfortable with it, but she does send “healing energy” to her patients and regards a family’s pursuit of medical treatment for a child as implicit permission for her to offer whatever healing she can to support the child. She received this guidance from her shamanic healing trainer (Dina, MD).

* “I realized that the patients coming to me weren’t going to engage in shamanism directly, but that their higher selves were leading them here to engage in shamanism indirectly. I realized there’s covert shamanism and overt shamanism. A lot of people aren’t ready to engage with spirit, but their higher selves were leading them here [to my practice].” He stated that he always journeys before the patient arrives to ask spirit what the client needs. And he added that the patient always receives some degree of shamanic healing because it is so integrated into who he is (Neal, DO).
Psychopomp

Shamanism not only provides a framework for addressing issues of physical and emotional/spiritual health, but also includes an ideology addressing notions of death and afterdeath. Many practitioners relayed accounts of “checking in” with their patient’s soul to assist or ensure that they had “crossed over” peacefully following their death. The use of shamanic skills to support individuals who are in the process of dying or who have already passed on (referred to as psychopomp) are described below:

* When I asked a practitioner how shamanism has affected his work with dying patients, he responded that “it’s been a real gift to be able to be there as a healing companion with an open heart. Your heart is much more open when you approach it from the point of the healer rather than the Western-trained diagnostician and clinician. So for me it’s been transformative in allowing me to bring more compassion and caring and empathy and love into addressing issues of death and dying” (Bert, MD).

* One emergency room nurse stated that she feels like she works “in a high-tech torture chamber. It’s pretty rough sometimes.” She has struggled to incorporate shamanic healing into her work because it is a high traffic area, but when she has a quiet moment with a patient, she can provide some healing such as calling on a power animal to assist, or in the case of someone dying, offer to help the person’s soul move to the light (Elisa, RN).

* A particularly interesting interview took place with an individual who has worked as a medical examiner for thirty years, as well as a medical practitioner. He uses his shamanic training as a means of ensuring that the spirits of recently deceased “don’t end up trapped in the middle world” and claims he has worked on hundreds of people. Because he often finds himself alone with the body in the morgue, he has the time and space to conduct psychopomp work, although he has to work quickly given that a pathologist or security guard might walk in. When I asked him to describe the process, he said that he always begins by creating sacred space and calling in his spirit helpers to guide him. He then asks that the spirit of the deceased be released and guided to an appropriate place. He does not use a drum or rattle or any other shamanic tool, again because he says he would feel awkward if seen by someone; but also feels he does not need them to do his psychopomp work.

In one example he recounted a woman whose son was killed in a car accident while she was driving. The woman was distraught and blamed herself for her son’s death. The practitioner tried consoling the woman, but felt it did not help, so he did a journey in which he returned to the scene of the accident. He
found the boy’s spirit wandering about, still looking for his mother, so he asked for the boy’s spirit to be released, calling on the boy’s deceased relatives to come and escort the boy toward the light. A few days later, the practitioner learned that the woman was in a better emotional state.

In some cases, he has found his guides tell him not to do any psychopomp work as a matter of self-protection. He recounted a situation where his guides told him that an individual was possessed by an entity and that they could not protect him against it if it was released during psychopomp work, but that they would return later with “reinforcements” to help the deceased person and guide their spirit to the light (Everett, MD).

**Other Uses**

Some practitioners have also used shamanic work in their profession to address other concerns besides those of their patients. Two examples below describe their practice of shamanic skills to benefit their staff and their physical environment:

* One practitioner noted that she has given her office staff some training in shamanic healing as well so they can better support her work with patients. She noted that one patient came in who was angry and so after he left, she sent each of the staff members to the four corners of the building to pray for the patient – each in their own customary tradition – as a means of clearing the negative energy from the office (Kayla, DDS).

* Although a practitioner had a policy of not performing shamanic healings on her patients at her medical office, when she learned that many people working in her building believed it was haunted, she performed a covert healing ceremony on-site, portraying it to others as a local history project (Linda, MD).

**Barriers**

While it is important to exemplify how practitioners introduce and/or incorporate shamanic healing into their professional practice, it is just as important to investigate the reasons why they avoid or choose not to do so. Interviewees noted a number of different concerns about or limitations to practicing their shamanic skills. The general categories of limitations are: institutional, collegial, patient-related, circumstantial, and training.

Institutional barriers were the most commonly cited. Examples below include prohibition, or perceived lack of acceptance, from employers, medical boards, insurance
companies, and the judiciary. It should be noted that practitioners who have a private practice expressed much less concern about institutional barriers than those working for larger organizations and/or public institutions.

* “I’ve had patients come in who would be carrying on a conversation and their aide would tell me not to interrupt them, ‘They’re not seeing anybody, but they like to talk to themselves.’ Well, when I look at them, I can see them talking to somebody. But I’m not in a position to say that, because I’m the [practitioner]. For the hospital that I’m working for, that would be viewed as encouraging their disease” (Emma, DMD).

* A nurse who works in a long-term health care facility stated that she does not feel she can practice shamanic healing at her workplace, though she feels her “energetic presence” supports the patients. “The administration doesn’t say ‘don’t use it,’ but when I try to talk to them about shamanism, they just don’t understand it. They don’t mind what I do on the outside [i.e. reiki and shamanic healing], they just don’t want me doing it in their health care facilities.” However, she noted that she recently did some journeying for a patient who was ready to “pass over” and felt it was beneficial to both the patient and the family (Nina, RN).

* A practitioner stated that if his peers knew that he was consulting spirit guides and doing psychopomp, they would think he “had lost it” and noted that the medical board governing his field of specialty does not recognize alternative therapies, including shamanism. “They kind of persecute people [with a medical license] who practice [shamanism],” adding that he has met many physicians who have given up their medical license in order to practice [shamanic healing]. He would like to practice psychopomp in a hospital, but does not feel that would be allowable as yet for a licensed MD (Everett, MD).

* A geriatrician mentioned that her malpractice insurance form asks whether the practitioner is practicing anything considered to be complementary or alternative medicine. Although she does not practice shamanism on patients in the hospital where she works, she cited this question as a concern that answering it in the affirmative could be a justification for costlier malpractice premiums (Urma, MD).

* A practitioner who works as a sexual assault examiner told me that she incorporates shamanic healing into her practice “in a very general way” by practicing the spiritual principles, “but not in a specific way. My examination is very specific, and there are boundaries that can not ever be crossed, partly because my work is medical legal stuff. I sometimes end up testifying in court, and I can’t do anything to make my professional boundaries look poor” (Denise, RN).
Many practitioners are concerned about their reputation among colleagues and superiors, even members of the non-medical healing community:

* One physician stated he works in a very conventional setting and that his “colleagues and superiors wouldn’t be open to it . . . I’m not in a context where I’d even think about suggesting shamanic work to any of my patients.” Although he notes that his shamanic studies has allowed for an “improved awareness and growth as a person” that increases his effectiveness as “a leader, manager, and practitioner” (Carl, MD).

* A physician assistant who works in a hospital and runs a private shamanic healing practice at home told me that she finds it difficult to practice shamanic healing at work, although she noted that she sometimes does so covertly. She is concerned that she will frighten the patient or that the patient will tell the doctor. “I don’t want to get a reputation for being regarded as nuts, or ungrounded, or unsafe. Physicians feel very threatened, really, a lot of them do” (Ellen, PA).

* “There’s a huge bias and suspicion in medicine against witch doctors, and cranks, and whatnot which I share. But I’m also disillusioned with scientific, quantitative medicine because of its reductionist nature and the materialist assumptions it makes.” This MD added that he knows other doctors who practice shamanism, but they are very quiet about it for fear of being ostracized by the rest of the medical community. But he also has sensed a distrust from non-Western trained healers who are concerned about how the medical community will use and control the practice of shamanic healing. He expressed the concern that there even might be a backlash from his own patients (Teddy, MD).

As the above quote mentions, patient-related concerns are another barrier, either because of distrust or disinterest:

* While most of those I interviewed work with a more mainstream population where the lack of knowledge (and sometimes trust) of shamanism prevails, this particular MD works with “a number of immigrants from shamanic cultures.” She stated that the reason she could not practice shamanic healing overtly is because she does not fit the image of a shaman to many of her clients; of which many are from Laos (Mien and Khmu) where the shamans are traditionally male. “So being female, and not speaking their native language makes it difficult in that respect.” She added that she is able to work in “energy dynamics” and encourages her patients to see their community shaman and combine it with their Western treatment. “It helps tremendously to have a good familiarity with a shamanic worldview to have more of a clue about what they are thinking and feeling and what their agenda is” (Linda, MD).
* Some practitioners have noted that disinterest or lack of acceptance by patients occurs in part because they want a “quick fix,” a reflection of “our” society’s broader attitudes. “They don’t really understand that they’ve created the problem and that they’re the ones who are going to have to undo it. They just want the pill, they just want the surgery” (Ellen, PA).

* Through talking with a patient, an MD says she often gets visions, which sometimes involves helping a patient create a healing ceremony for themselves. “Rather than me doing an official healing on somebody, my role as I look at it, is to teach somebody how to work with healing themselves. Unfortunately with allopathic medicine, too many people come in and want me to fix it” (Carmen, MD).

* “People don’t feel they have to make an active decision to heal. People might spend money on a new suit, but not on a shamanic healing” (Neal, DO).

In some cases, the limitations were more circumstantial or logistical. Shamanic healing takes additional time, and typically is practiced in a quiet setting. Settings such as emergency rooms and intensive care units are not conducive to these parameters:

* A nurse practitioner recently left her position as an emergency care nurse in an ICU to practice in a hospice. She noted that there was no time to practice shamanism in an emergency unit, but hopes to be able to use her training in her hospice work once she has settled in (Elaine, RN).

Through interviews and in various articles, there is agreement by most that shamanic healing is not a skill learned simply by training—there has to be some degree of natural ability. However, a certain amount of training is necessary for most to advance their shamanic skill level. Two interviewees mentioned concerns or limitations to attaining further formalized shamanic training:

* An MD expressed concern about the cost of shamanic training. He noted that the Buddha and Jesus Christ did not charge for their teachings—although they did ask for commitment and sacrifice. He and his business colleagues do not turn away anyone who needs treatment, even if they do not have insurance, and patients often pay as a donation and are thus “paying from their heart.” Because traditional shamans usually received items as barter, rather than money, “I feel uncomfortable having to pay for ‘enlightenment’” (Teddy, MD).
* Another practitioner stated he would like to pursue more training specifically with FSS, but FSS requires attending basic FSS workshops before taking the advanced. Since he is already trained in the basics of shamanic healing, he does not want to pay for more basic training, which thus prevents him from registering for the more advanced programs (Sam, PA).

**Responses to Shamanism**

“Some people feel shamanism is witchcraft – a cultural overlay of distortion given to people by the church” (Neal, DO).

The above quote expresses one practitioner’s extreme perception of the public’s opinion on shamanism. During my interviews, I probed practitioners for reactions to their discussion and/or practice of shamanic healing work, from employers, colleagues, and patients, as well as family and friends. Aspects of this question were discussed in the above section with regard to institutional barriers and a practitioner’s concerns for his or her reputation. In this section, I disclose a range of noted reactions from the very positive, to the curious, to the questionable, to the diabolical.

Reported collegial responses were varied, some more derogatory while some more equivocal or receptive:

* An MD who works for a very large health care company stated he has been able to discuss shamanism with one of the high-level executives and has conducted power animal retrievals for some of his colleagues and friends, though his colleagues have not pursued study of it on their own (Carl, MD).

* An MD said that she usually does not talk to her colleagues about shamanism, but when she has done so, she “usually gets blank stares” (Urma, MD).

* Although many practitioners in the medical field express a feeling of isolation in their shamanic work, the feeling may be even more predominant in the field of dentistry. One of the dentists I spoke to stated she only had one collegial confidant, and that “it’s very different in dentistry. Medicine is a little more open. Dentistry’s more black and white.” She also stated that she gets told “I’m crazy” a lot. They think I’m a little different.” However, after successfully working with a very aggressive patient deemed criminally insane, who arrived in shackles, but then fell asleep in her dental chair, she became known as “the magical dentist” (Emma, DMD).
An osteopath stated that other members of his profession think he has “violated the soul of osteopathy” because of his combining of shamanic healing with the more technical approach of osteopathy, and they think he is “weird.” Later in the interview he adds that a lot of doctors do not personally espouse his practice and will “bad mouth” him when given the opportunity, yet “if either they or their loved ones are hurt, I’ll be the first one they go to. So there’s this funny place where you’re sort of shunned by your colleagues, but honored for the integrity of your work.” He compares his situation to traditional shamans who often were feared and ostracized by their community, and yet the first person a tribal member would solicit for help when there was a problem (Tim, DO).

In turn, some of the practitioners who are practicing shamanic healing expressed a degree of condescension for those who maintain a rigid biomedical approach to health care:

* An interviewee explained that the name of a new medical specialty “Holistic Integrative Medicine” was adopted because most physicians are more comfortable with the term “integrative” than “holistic,” but since integrative physicians are not necessarily holistic, the two words were combined in the title. Also the founder of this named specialty, the interviewee added that he feels that most integrative physicians “recognize the mind–body connection, but are still pretty much in the dark when it comes to the spiritual” (Stan, DO).

One practitioner works at a University hospital that has been very receptive to allowing him to practice shamanic healing and even to go so far as to institute a policy regarding the practice of alternative and complementary healing that includes shamanic. The policy includes a statement acknowledging that patients want these practices available in the hospital and therefore, they are acceptable as long as they are not a substitute for standard treatment nor an interference with day-to-day patient care (Bert, MD). However, an osteopath expressed concern about how shamanism will be incorporated into the medical field:

* “There is somewhat of an overly academic approach to integrating shamanism with biomedicine, and a hierarchy of dominance that’s playing out. MDs feel they’re going to lead the way, and those without medical degrees are going to be below us.” He added that there is a need for equality and respect of different
Some Western-trained medical practitioners have also experienced disdain from shamanic practitioners who are not medically trained. When I asked interviewees about their experiences as medical practitioners attending shamanic healing workshops, I received some interesting responses:

* One MD stated that she felt very self-conscious about “being an allopath” in shamanic classes. “There’s quite a lot of judgmental contempt against allopathic medicine and people who practice it, that I find very difficult. I would get questions from other participants like ‘What are you gonna do with it?’” She added that near the end of her three-year shamanic training, her workshop colleagues rhetorically asked her what she was going to do with her new skills, quickly suggesting that she become a “recovering allopath” (Linda, MD).

* In contrast another MD stated that she did not feel uncomfortable in the shamanic workshops she has attended, but added that she does not usually mention that she is a physician. She also noted that Michael Harner was appreciative of having physicians attend his trainings as he wanted “to bridge this gap between shamanic healing and Western medicine” (Dora, MD).

Practitioners also relayed experiences of presenting their shamanic work to a broader audience, with mixed results:

* A practitioner stated that he does not talk about shamanism with his colleagues very often as he feels they are not open to it, but was recently invited to give a talk on its practice at an area hospital. He added that 35 people showed up and was informed afterwards that it was the largest attendance for a lecture within the series in which he participated (Neal, DO).

* A practitioner recounted one very difficult moment for her when she gave a talk about shamanism at a Unitarian–Universalist church. Afterwards a woman approached her and scolded her for talking about ‘pseudo-science’ and then began referencing extremist views about religion and fighting in the Middle East. “I felt like she was equating me with a terrorist. I was very, very hurt by that. Man, that took all the transmuting of the negative energy that I could possibly do” (Denise, RN).
Financial Aspects: Fees, Insurance, and Certification

The issue of charging for shamanic healing is debated, in part because in many traditional societies, shamans did/do not charge money for their services, though some form of reciprocity occurred through barter and/or gifts. The question was posed to practitioners as to whether they charged for their shamanic services. The majority of responses reflected that it is primarily a matter of whether the shamanic healing was offered separately (the fact that some practitioners have a private practice on the side of their medical health care position) or in combination with a medical treatment. One practitioner stated that she does not charge for shamanic healing when it is included in her medical practice. But if a patient comes in specifically to receive a full hour of energy work, then she includes it under an appropriate insurance code related to the patient’s concerns (e.g. there are a lot of medical codes for TMJ) (Kayla, DDS).

Another practitioner stated that one way in which to receive compensation for shamanic work is to combine it with treatment that is covered under established insurance codes (Carmen, MD). For instance, a practitioner may charge insurance fees based on using codes for the pathology, rather than the treatment. An osteopath states he bills for the osteopathic manipulation and “throw[s] in the shamanic work for free” (Neal, DO). For those who charge for a separate shamanic healing session, quotes ranged from $110-$150 for a 60–90 minute session.

The more contentious question is whether shamanic healing should be covered under health insurance. Most insurance companies only cover conventional medical treatment, although in recent years, coverage has expanded to include more alternative/complementary treatments, such as acupuncture and therapeutic massage.
The fundamental issue underlying the question of insurance companies covering shamanic healing has to do with the issue of certification. If insurance companies are to cover such a practice, then it is understood that shamanic healers would need to be certified to receive insurance copayments. This is where shamanic practitioners are very divided on the issue. Below are reasons as to why some practitioners are in favor of insurance coverage, and certification of shamanic practitioners:

* One practitioner stated that she feels the only way that shamanism will be accepted into the mainstream is through a certification process, and that “codifying such practices will be necessary in order to cover the costs of treatment” (Emma, DMD).

* An MD feels that certification is needed as well as “a watchdog group” because there are too many people who may practice it without being adequately trained. “Shamanism is one of those things that can be done wrong, can be done badly . . . for instance, to do a soul retrieval on someone and then just walk away is the worst thing you can do to someone.” Certification is needed because “the fly-by-night people” may be harmful and detract from the reputation of the practice as a whole (Carmen, MD).

* Another MD feels certification is necessary to protect patients from being taken advantage of by a caretaker in an authoritative position. He was warned by one of his teachers that “there are a lot of ‘kooks’ that go to shamanic workshops, so you need to be careful.” He noted that in medical school, students are weeded out through the process, and those who do not have adequate interpersonal skills may be redirected to areas such as anesthesiology, pathology, or research. With respect to practicing shamanism, “it’s more than just being able to journey and get information. You have to be able to communicate and present that information in a nonjudgmental way” (Everett, MD).

A co-founder of the American Board of Integrative Holistic Medicine feels that this board may be the means by which to certify shamanic practitioners, as it is the only certification for alternative medicine within the medical establishment (Stan, DO).

[Although it should be noted that although the American Holistic Medical Association}
lists a number of alternative therapies on their website, shamanism is not included.\textsuperscript{32}]

Another practitioner feels that receiving insurance reimbursement for shamanic work as a legitimate practice makes sense to him. The problem comes with the need to certify shamanic healers to allow insurance billing. Certification involves human judgment and this means the individuals judging a healer need to be able to understand what the healer is doing. And he does not feel that anyone is skilled enough to sit in judgment.

“Judgment and certification is an ‘ordinary reality’ device, so how can you apply an ‘ordinary reality’ device to a ‘nonordinary reality’ practice?” (Tim, DO). Other concerns regarding certification are expressed as follows:

* A practitioner expressed the opinion that while some sort of governing board might be beneficial, she feels it would be difficult to set up a certification program. “Ultimately, people will attract to themselves the kind of healer based on their intentions. Certified or not certified, you’re gonna get what you bring to yourself anyhow. That’s just a spiritual law. So you can govern all you like, but like physicians, physicians are licensed and yet there’s only a handful of them that I would go to out of all the physicians I know” (Ellen, PA).

* An MD stated that she felt health insurance will never cover shamanic healing because “it requires evidence-based data and you’re never gonna get it”; it would require treating each person the same which is not appropriate to shamanic work; and it would be difficult to certify a healer. For instance, if the criteria were partly based on coursework, “there are people who’ve taken every class and they’re lousy healers, and there are people who are naturally gifted healers who have only worked with one teacher and then the Universe opens up to them. There’s also a major judgmental piece in this. There’s a lot of backstabbing in this community” (Dora, MD).

* Another MD stated he is against certification because “having a piece of paper to say that I finished a training doesn’t make me a decent shamanic practitioner. The process of certification is messy. We’re taking the whole thing out of the context of where the anointment comes from. You’re not anointed by your

\textsuperscript{32} The American Board of Integrative Holistic Medicine (http://holisticboard.org) is the certifying body for the American Holistic Medical Association (www.holisticmedicine.org) which was founded in 1978. At this point, each site’s list of “specialties”/“area of specialty” includes a long list of alternative modalities, but shamanism is not specifically included as a separate category.
teachers in ordinary reality. It all comes from your work with something beyond yourself. The certification process and governing licensing body makes the determination an act of human judgment” (Bert, MD).

* Another practitioner does not feel that there is a need for a certification process because “spirit will weed out unfit practitioners.” Certification might also exclude naturally gifted healers. “Certification is a linear process and doesn’t include non-linear concepts so how valid is that? It’s repeating a system of hierarchy” (Neal, DO).

It should be mentioned that I spoke with a practitioner who has received insurance payouts from certain companies within an HMO for shamanic healing services. A small number of companies collaborated to create a wellness program that includes coverage for employees and their families for soul retrieval, as well as other alternative treatments such as naturopathy, chiropractic, and massage therapy. However, as word spread and many other shamanic practitioners began to investigate using the HMO as a model for compensation, the HMO reportedly became concerned that it might disturb Christian members (and potential members) who opposed shamanic healing on spiritual grounds, and warned that it would only keep the program running “as long as it stays quiet.” My informant added that the participating companies found their annual payout to be half the national average for each year that they have run the wellness program. He gave examples of three clients who were diagnosed with terminal cancer. After each received one two-hour shamanic healing session at a cost of $75, each client went into remission and thus saved the company hundreds of thousands of dollars in conventional cancer treatments (Nathan, psychologist). Clearly, the issue of whether insurance companies

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33 When I quizzed my informant on why an HMO would sacrifice potentially hundreds of thousands of dollars in payouts, I was told that a very high percentage of residents were covered under an HMO in this area of Wisconsin and thus it is a very competitive market. Given that 39% of the U.S. population identifies themselves as evangelical Christian (based on Gallup polls), the religious beliefs of this sector are of key importance. My
should or will cover shamanic healing is a very contentious issue and though the possibility is there for the future, it may not occur any time soon for a broad spectrum of the public.

**Future Goals and Portent for Increased Cultural Acceptance**

“The world is still sleep-walking. We’re living in a synthetic world. But there is an emerging global shamanic culture happening. We are now ending a thousand years of darkness and moving into the light” (Neal, DO).

Practitioners often expressed their goals for the future, both for their own professional development that included shamanic healing, as well as its role in the broader context of public acceptance and benefits:

* One practitioner stated she would like to continue studying and practicing shamanism, specifically gearing her work to treat “a forgotten population, those who are mentally retarded and nonverbal” (Emma, DMD).

* Shamanism could be very beneficial to American culture, but “we have to respect the fact that [Americans] are not one culture; we are a conglomerate of multiple cultures that have little pockets of cultures within it . . . The first rule of being a family practitioner, or even a good shaman, is to understand your community. If you live in a small village, say in Nepal, you may just be working with one culture. But in this country you do not have just one culture, you have to be savvy enough about cross cultures or you’re not going to be effective.”

  “While I work with people individually, I also live in the town I work in, so I’m also trying to build a community of shamanically-trained people, sort of like through the ripple effect . . . Teaching is my key role. The biggest thing I can do is live by example. In other words, what I do shows people what is possible. And by living here, I can actually come out of the closet a little bit” (Carmen, MD).

* Some practitioners expressed an interest in leaving their positions in the medical field to open or expand a private practice in shamanic healing. Others have stated their intention to expand their shamanic work within their existing medical practice. One practitioner noted that, in part, it is financially difficult to start a private practice. As well, she feels drawn to bring the two [modalities] together; informant also stated that other HMOs in the same area renounced the idea of covering shamanic healing even after they learned of the cost savings due to the potential loss of members who are fundamentalist Christians; and the concern of upsetting indigenous peoples in the area who might take offense at white people practicing shamanic healing.
and wonders that it may be her job “to bring something so woo-woo into something so linear” (Elisa, RN).

* Greater use and acceptance of shamanic techniques in Western medicine might come through up and coming medical students. “If training in alternative/complementary medicine grows within medical schools,” this might be a means through which “to validate” the combined practice of two different modalities (Teddy, MD).

Other practitioners have taken on more programmatic goals to encourage the practice of shamanism:

* An osteopath who just began working in a holistic private group practice and has been affiliated with the American Holistic Medical Association and American Board of Holistic Medicine for the past fifteen years, initiated a movement in a new specialty—integrative holistic medicine—of which there are now over 900 board certified integrative holistic physicians. Since discovering his shamanic healing gifts, his goal has been to transform health care and “create a safe vehicle within which I could practice my gifts” (Stan, DO).

* One interviewee, Connie Grauds, RPH, is a certified pharmacist and author of a book, Jungle Medicine. She received a shamanic initiation in the jungles of Peru where she has continued to visit for the last twelve years. Although she does not feel that there is much resistance to herbal medicine in the field of pharmacy, she left conventional pharmacy to found the Association of Natural Medicine Pharmacists and begin a practice in shamanic healing, also founding a non-profit organization, “The Spirited Medicine Alliance.” She is now spending a portion of her time in Minneapolis to design and teach at the nation’s first college degree program in clinical herbalism and the first and only diplomaed program in shamanic studies at the Minneapolis Community and Technical College. Part of the goal of this program is to foster a working relationship between the students and area hospitals as a way of introducing shamanic techniques into medical centers. “Our goal to begin with right now in the shamanic studies program is to create shamanic community, and by that I mean at least an awareness that shamans do exist.” She adds that not everyone who graduates from the program necessarily will choose to practice shamanic healing, and by no means does the program claim to produce shamans (personal interview).

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34 Integrative Holistic Medicine is founded on two beliefs: (1) that unconditional love is life’s most important healer; and (2) that the loss of love is our greatest health risk, as supported by such research as the “Harvard Mastery of Stress Study,” a longitudinal study of Harvard medical students that began in the 1950s by Russek et al. (see “Psychosomatic Medicine” Vol 59(2):144–149, 1997). [per conversation with Dr. Rob Ivker, past President of the American Holistic Medical Association.]
Another method to validate shamanism in the medical community is through research. There are studies underway to evaluate its efficacy as a healing modality. If a scientific method can be devised to measure the healing outcomes of an alternative practice, it may gain acceptance through scientific validation. And yet measuring the efficacy of shamanism may be like attempting to measure wind velocity with a thermometer. Can it be done within the framework of a biomedical model? Scientific measurement of efficacy is problematic in the field of medical research and its very conception is debated within the field of medical anthropology. Consensus on how ‘efficacy’ in traditional medicine is defined and operationalized “remains elusive” (Waldram 2000). As one practitioner notes, people who receive healings may heal in various ways, but not necessarily for the condition being treated. “The higher self has its own agenda.” She referenced patients on whom she performed a shamanic healing who experienced improved physical, emotional, and relational conditions, but still suffered from the disease in question. “I think the [medical community] is going to have to allow that this modality works the best for the patient in the moment. You can’t ascribe or look for a specific outcome” (Ellen, PA).

**Conclusion**

As the above quote signifies, shamanism is a broad practice with great individuality – for the patient as well as the practitioner. The manner in which Western health care practitioners acquire an interest for and knowledge of shamanism, their training, their application and experience with it, as well as experienced reactions, results, and outcomes are incredibly varied as reflected in survey responses and interviews of 27 individuals. The efficacy of shamanic healing in biological terms is not yet measured,
though individuals have reported personal experiences of its possibilities; but just as
significant is its cultural import. As shamanic healing enters into the Western mindset
and into our health care system in the United States, its healing potential may also
increase. Where shamanic healing can be practiced and accepted is a first step in the
viability of measuring its efficacy. But as well, understanding its broad implications of
healing is just as important, given that the scientific measures of its medical potency may
not reflect the many other benefits it affords. In this one chapter, numerous quotes
intimate shamanism’s healing attributes for the practitioner’s life experience, both
professionally and personally. But also many quotes relay the challenges encountered in
adopting a philosophy and practice counter to mainstream Western culture and the
biomedical model of health care. In chapter 7 I will provide analysis of the findings
presented in this chapter as well as the two chapters to follow.

The following chapters 5 and 6 will provide investigation of a different model for
practicing shamanic healing within medical establishments in the United States. This
model has been dubbed the “Collaborative Model” as a contrast to the “Individual
Model” just enumerated. Chapter 5 will provide background on True North Health
Center and chapter 6 will delve into the collaborative model practiced at True North.
CHAPTER 5

TRUE NORTH: CHANGING THE DIRECTION OF HEALTH CARE IN AMERICA

Introduction

True North is a 501(c)(3) nonprofit organization that is changing health care and inspiring individuals to live healthier lives through integrative care, education and research.

True North began in 1996 as a discussion-group about how healing can be improved, and after seven years and 4,000 hours of volunteer time, it became an independent organization in Falmouth whose vision is to be the leader in integrative health care. Through its work True North wants to change how health care is delivered in Maine and in the nation. True North dreams for a small group, but as Medical Director, Bethany Hays, MD notes, “At True North we believe that nothing short of changing the world is worth doing” (http://www.truenorthhealthcenter.org).

The above quote is a brief self-description excerpted from True North Health Center’s website. As can be seen, the health center’s mission is nothing short of monumental. And during the nine months that I spent conducting ethnographic research and interviews, I was struck by the staff’s lofty vision and the immeasurable amount of time, energy, and personal commitment exerted to implement its mission without losing sight of the value of the process by which to reach such ends. True North Health Center (True North or TN) not only places a premium on health care outcomes, but also on the very process itself of delivering health care.

As I noted in chapter 2, a great deal of networking was required to locate and receive approval to conduct ethnographic research at True North. My initial goal was to pinpoint a physical site, such as a health center or clinic, where shamanic healing was practiced alongside Western medicine. At this point in time, True North is the only
known center of its kind, though there is a growing demand for consults by other organizations interested in replicating True North’s model. However, True North turned out to be a very special ethnographic site in more ways than one. Not only does it staff shamanic healers (two to be exact), but one of True North’s goals is to promote a collaborative model of healing whereby alternative practitioners work with Western practitioners to address patient conditions in a more holistic approach. Thus it provides an interesting contrast to the Individual Model discussed in the previous chapter.

Secondly, True North is founded on Circle Process. Although inclusion of Circle Process in my ethnographic research at True North fosters almost two dissertations in one, once I began to observe this approach to organizational management, I realized it was impossible to leave it out of the equation of the analysis. Circle Process is the foundation of True North’s operation, and serves as a pillar to the collaborative health care model. Just as it would be impossible to study ocean currents without including data analysis of the prevailing winds that drive such currents, the operation of True North cannot be understood without the acknowledgement of Circle Process.

**History of True North’s Founding**

From Division to ‘Divine Vision’

In 1996 three nurses working at Mercy Hospital in Portland, Maine met for lunch and began to discuss the need for a different approach to health care (of which two, Kathryn Landon-Malone and Kristen (Kris) Lombard, stayed on to become members of True North). They decided to invite other members of the hospital to meet early on Tuesday mornings, experiencing a fast-growing attendance. With permission from hospital administrators, the nurses posted flyers around the hospital, and at the very first
meeting about twenty people showed up—which the organizers considered to be a significant number given the many ongoing events at the hospital. They also assumed only clinicians would show up, but other hospital staff attended, such as pastoral care, social workers, dieticians, housekeepers, carpenters, environmental services staff, and administrators. Their “operating question” was “‘How can we do holistic care in a different way, in a healthy way?’ – because our experience had been otherwise” (Kristen Lombard, RN). As word spread, other health care practitioners from the wider Portland area, many of them alternative (e.g. massage therapists, reiki practitioners, and polarity healers), began to attend the meetings as well. Ultimately more alternative healers attended than RNs and MDs. The group named themselves the Mercy Hospital Holistic Council (the Council) and spent their meeting time discussing how to introduce holistic care into conventional Western medical settings.

One of the Council’s objectives was to determine the best available evidence-based complementary practices and to educate physicians about them, thus promoting complementary practices at the hospital that were safe, effective, and carried policies, procedures, and credentialing. No MDs showed up for the first few months, but the first MD who attended, Dr. Bethany Hays, stayed on and helped charter the actualization of True North. Bethany then invited two shamanic healers, Allie Knowlton and Evelyn Rysdyk, who also became key participants in the development of True North, and continue today as practitioners there. Although people joined the Council by invitation, there was no specific plan to include certain types of healers, and no discussion about including shamanic healers, but Bethany invited Allie and Evie because “they are bright and funny” (Bethany Hays, MD). When I asked one of the founding RNs if there was
any expressed concern about two Council members being shamanic healers, she stated that she had not heard any such comments, noting that because the Council already had members such as polarity therapists and the like, that “we already had all the weird people, you know, we were the fringe people, so when the shamans showed up, it was like ‘oh wow, we just got some more weird people, it’s ok.’” She added that one of the joining MDs, who previously practiced as a surgeon, stated his interest in shamanism and declared that awhile back he “put down his scalpel and picked up a drum” (Kathryn Landon-Malone, RN).

From the beginning, the group opened each meeting with a meditation, sitting around a sacred center in which meaningful objects (including a teacup representing hospitality and relationship gifted by Sister Consuela of Mercy Hospital\(^\text{35}\) were placed as reminders of the Council’s objectives: (1) to investigate and integrate new ways of healing; (2) to educate health care practitioners, administrators, and patients about these new healing methods; and (3) to deepen the delivery of care for patients as well as for each other. One of the founders’ key visions was to promote “relationship-centered” health care whereby practitioners are in relationship with their clients and supportive practitioner–practitioner relationships are fostered.

After a few meetings, founding member Kathryn Landon-Malone proposed that the group try “Circle Process” as described in a text by Christina Baldwin, *Calling the Circle: The First and Future Culture* 1994—what might be considered the “bible” of

\(^{35}\) Sister Catherine McCauley started Mercy Hospitals in Ireland in the early 1900s. When she was on her deathbed, she asked the sisters to be sure they had a cup of tea to be comfortable. That’s how the teacup came to represent hospitality and relationship for them.
True North’s practice. This practice is based on the ideology that the “circle is an organizational structure that locates leadership along the rim and provides an inclusive means for consultation. Circling is a useful structure for learning, governance, creating community, providing services, and observing ritual.” Furthermore, the “circle reintroduces the idea that different perceptions are both valid and helpful, and that they do not have to compete with each other for dominance” (Baldwin 1994:34). Circle Process includes the practice of an initial “check-in” whereby each member makes a statement as to how they are feeling, or what is going on in their lives, or answering a question put forth by the Circle. In the first few years, Kathryn noted that attendees would typically introduce themselves by their name and title, but as time went on, people just stated their names (i.e. omitting their professional title and status), and “began building trust and focusing on relationship building.” Sometimes as many as fifty people showed up for the meeting, and thus it would require a “quick” check-in; and sometimes check-in dominated the majority of the meeting time (Kathryn Landon-Malone, RN).

Another key aspect of the Council was an acknowledgement of “Spirit,” a nondenominational presence that guided the group’s process. Although Mercy Hospital is a Catholic-based charter, the Council was not founded on any particular religion, but on the “universal sense that we’re all connected to something greater . . . whether you call it ‘collective consciousness’, ‘divine spirit’, ‘God’, ‘higher power’, it doesn’t really matter, it’s sort of a felt sense of what fits your belief system.” The Council’s Circle Process included an understanding of “asking for what’s greater than we are” (Kathryn Landon-Malone, RN). True North’s website describes its beginnings with the acknowledgement that Council members “purposively held Spirit in the center of our
circle and relied on the collective wisdom of the group to create something greater than the sum of our parts” (http://www.truenorthhealthcenter.org/beginnings/index.html). Kathryn noted that if True North had been borne out of a secular institution, such as Maine Medical Center, it might have been different. When I asked Kathryn if anyone expressed offense at the use of the term “spirit,” she said she was not aware of such, noting that even Sister Consuela and the Chaplain of the hospital were open to the idea of calling on Spirit for healing work (Kathryn Landon-Malone, RN).

One Council member noted the various array of healers and hospital staff who attended Council meetings. This fostered a rich conversation about “what is healing, what does it mean to be healed, who does the healing, how do we learn to heal, and do we really do any healing at the hospital?” When I asked my interviewee if the Council ever came up with an answer, she replied “Yes, we all agreed that there are many paths to healing. Healing includes a spiritual component, a sense of being whole, whether you are well or not. A healer is someone who helps to make whole another human being” (TN member #9).

Some people came for a few meetings and never returned, disinterested in the slowness of the process, but others became regulars – for months turning into years. “The dreamers stayed on and the doers got frustrated and left,” but after a fundraising letter went out to all who had participated, some folks returned (Kathryn Landon-Malone, RN). When True North Health Center opened in 2002, the Council phased out. Although Mercy is building a new hospital at present, there are no plans to build a holistic in-patient program. Presently, eleven practitioners who now work at True North participated in the Holistic Council at Mercy Hospital.
Two of the three nurses who first met, Kris and Kathryn, participated throughout the entire brainstorming process and now work at True North. Kris noted in my interview with her that when they first began to meet at Mercy Hospital, “we certainly had no idea that it would look like this” [referring to True North Health Center], but our reason for coming together was “about bringing complementary therapies into a small community hospital – and not about Circle Process or out-patient service.” According to Kris, it took 4,000 volunteer hours over four years to develop what they termed “The Integrative Medicine Program.” At one point the hospital said they did not have the money to run an in-patient or out-patient program, but “people then said they weren’t going to let go of the dream” and so Dr. Bethany Hays began fundraising. At this point the hospital administration began taking the Council more seriously, asking Kris and Bethany to serve as co-directors of the Division of Integrative Care which opened in 2001 – though there was never any physical space dedicated to it (Kristen Lombard, RN).

Kathryn relayed to me that the Council did not like the term “division,” deemed by the Mercy Hospital Board of Directors, but they decided that “di” could stand for “divine” and thus the program was a “divine vision.” Kathryn also relayed the time a CEO of the hospital attended one of the Council meetings and did not know where to sit because there was no end of the table at which to take a seat (Kathryn Landon-Malone, RN). Although the CEO backed the Council after observing its functions, Mercy Hospital officials ultimately pulled back their support due to financial constraints as well as accreditation concerns. Given that the proposed membership of practitioners included “alternative” healers—even shamans—hospital officials were concerned Mercy Hospital
would lose accreditation from the Joint Accreditation for Hospitals (JAHO) (Bethany Hays, MD).

When I asked one of the participating nurses what felt unhealthy about working in a standard medical institution (of which she has had many experiences including in-patient and out-patient facilities, and nursing homes) she responded that in hindsight, that for one, relationships were suffering, and secondly, that from a nursing perspective, there was a sense of powerlessness. She mournfully referred to “a voice that was allowed to speak, but never listened to.” The interviewee went on to further explain her views including the belief that physicians dominated the decision-making process; and in general, health care institutions emphasized productivity, the bottom-line, and a credo of “do more with less” that ultimately obviated a nurse’s ability to take time to be in relationship with their patients. “And what we know now is that relationship is a critical piece of the healing process. Nurses were getting burned out from the physical and mental expenditure and the emotional suffering from not being able to practice the kind of profession they had meant to do” (TN member #1).

Another TN member who sat on the Council noted that the goal was to create a health center that served patients as well as promoting healthy relationships among coworkers. “Hospitals are one of the most toxic work environments that there is. People who work in a sick professional environment can’t have the personal clarity to do impeccable health care” (TN member #2). One Council member stated that her excitement about working at True North is “the opportunity to practice in a new way—and the icing on the cake is that we could do this experiment of Circle Process that had really been transformative for all of us” [during the Council meetings]. When asked if
she felt that she could practice health care the way she wants to without Circle Process, she replied that “it would feel very lonely” (TN member #1).

**Circle Process**

I think our [True North] mission is to set an example for a possibility for healing the health care system. Changing the health care system and making it whole. And I believe that using Circle Process is integral to that. I don’t think we would have gotten as far as we have and I don’t think we would succeed – as I believe we will – without Circle. I think there’s a spiritual aspect to what we do. And I think there is a kind of ethic which is an ethic of openness and nonexclusion . . . (Bethany Hays, MD).

My first day as an ethnographer at True North began by sitting in on the TN Circle. At 12:15 pm, staff members (totaling 22 at this meeting) entered the room and sat quietly in meditation in chairs arranged in a circle. A decorative cloth lay on the floor in the middle of the circle on which sat the same teacup provided by Sister Consuela, along with a lit candle, feathers, a few stones, and Buddhist chimes. About ten minutes later the designated facilitator (staff members voluntarily take turns) opened the Circle by calling for three deep breaths in unison, and then orating a chosen reading. On this given day, the facilitator chose to read a Rumi poem in honor of their Executive Director who was leaving her position at the end of the week.

Then it was time for “check-in,” a regular practice where the facilitator asks a question or provides some guideline for each member to express themselves briefly. Today the request was for each person to say their first name and then three adjectives describing how they feel, that begin with the same letter as their name. Members offered expressive, and sometimes humorous, words of self-description. The facilitator then asked if anyone had any announcements before moving into the Circle’s agenda. This included the introduction of myself to the group, as well as a new practitioner. The
agenda items for this day were brief, as the focus of this particular Circle was to say
good-by and honor two parting TN members: a front-desk staff member and the founding
Executive Director. The Circle continued with the offering of stories – many personal
and humorous – as well as accolades and gifts. The Circle closed with a meditation for
one of the member’s sister who was about to undergo an operation. We then all joined
hands and gave a yelp of celebration. Thus, even as a new visitor, I was integrated into
the Circle immediately.

Clearly this does not describe your typical boardroom or organizational staff
meeting. Interactions were much more personal and emotionally intimate, as well as
physical with respect to everyone holding hands at the closing. The fact that time was
taken for quiet meditation and for a personal check-in for each member is also a
statement of the TN members’ attempt at defying a driving business tenet that “time
equals money.” Check-ins often involved a comment about what was going on in the
member’s personal life, such as family concerns, stories of children or pets, relationships,
or accounts of healing. Or it might involve answering a specific question such as “How
are you feeling?” or “How are you feeling about True North?” Throughout my months of
attendance at Circles, I felt the sense of a shifting adage: “time equals relationship
building equals better health care.” As TN member Evelyn Rysdyk noted in our
interview, “It’s about relationships. If relationships work well, then the work goes well.”

Because the Circle called on attention to heartfelt emotions as well as mindful
attention to the issues concerning the center’s function (e.g. housekeeping items, setting
new policies, TN’s financial status, the debate of whether to accept health insurance), I
often felt personally moved as I sat there in observation. And as I sat there, I too was part
of the Circle. I found members were always professional and respectful, even amidst expressive or humorous or even argumentative exchanges. I also observed that it takes a strongly-knit group gathered in a safe “container” to be candid and emotionally expressive, to be direct, to poke fun at one another, to cry.

When I asked one practitioner how TN members have been able to carry out Circle Process, i.e. how have they reached a certain level of “emotional intelligence,” the response was “that we trust each other. And we trust each other because we’ve risked, and it’s been ok. And even in the darkest hours of our experience, we always came back, we always made sense of it all, and it made us stronger together” (TN member #1).

One of the tenets of Circle Process is “reverent participatory relationship” which honors the practice of “being in reverence and participating with another human being at the level of the soul for the purpose of healing” (Kathryn Landon-Malone, RN). This practice was initially proposed by the Vision Circle of the Holistic Council. The vision statement created for the Council includes the phrase: “We believe in being in reverent participatory relationship with individuals seeking healing.”

We then realized it was important for all beings, with each other, with hospital hierarchy, with patients, with anyone we encountered . . . When experiencing difficulty, it’s useful to ask ‘In what way are we no longer in reverent participatory relationship?’ Just remembering to ask that question got us out of some real pickles. We would then ask how to get back into reverent participatory relationship. The first thing you have to do is assume that you are in relationship, and then ask what is our relationship and how are we in relationship” (Bethany Hays, MD).

36 Emotional Intelligence “refers to an ability to recognize the meanings of emotion and their relationships, and to reason and problem-solve on the basis of them. [It] is involved in the capacity to perceive emotions, assimilate emotion-related feelings, and understand the information of those emotions, and manage them” (Mayer et al. 1999:267).
“We work in a place that is both human and humane. Besides the collegiality, there’s a
great deal of caring” (Evelyn Rysdyk).

Soon after completing her medical residency, a young practitioner joined True
North. She was drawn to its arrangement that afforded practitioners the opportunity to
work independently while also working collaboratively with other Western as well as
alternative practitioners. She entered medical school with the belief that a good standard
of health was predicated on “a healthy planet, social justice, and equitable allocation of
resources,” but that the present health care system in the United States was run as Big
Business, contrary to necessary values. Her first experience at Circle Process occurred
while applying for a position at True North, where she met with the Decision Circle
(made up of the Executive Director and some of the Western and alternative
practitioners). She feels that Circle Process supports her evolution as a practitioner as
well as her personal well-being. “Circle fosters the individual being committed to the
organization as a whole.” Check-in allows everyone to “gain a real knowing of each
person in the organization” and the ability to relate to members on a “heart-level” as well
as “mind-level, so it builds community. And because it builds community, and TN’s
foundation is relationship, it’s not just work, it’s a shared vision, shared adventure . . .”
(TN member #3). During one of the TN Circles I attended, discussion arose about
members arriving late for the meditation/breathing/opening reading and initial check-in.
One of the members reminded the others, “If you’re not here, you miss a richness of the
Circle – and the Circle misses your richness” (TN member #4).

Circle Process affords TN members the opportunity to “really know each other on
a very deep level.” And because of this, it allows members to be more confident about
referring their clients/patients to another TN practitioner, to feel that the other practitioner is “a person of deep integrity and honesty and someone who has the utmost skill in their chosen field” (TN member #5). More than one TN practitioner stated that they felt they were a better health practitioner and had better relationships with their patients/clients because of their experience with Circle Process. “Working in Circle has prevented so much of the social crap that happens in business organizations that I’ve worked in before. It takes the ego out of the room.” And because of Circle, “I am able to be more present with my patients because my head isn’t spinning with things going on outside the room” (TN member #2). Practitioners have also mentioned the casual means by which they can interact with each other at True North—in part due to the physical lay-out of the office—and at times quickly check in on concerns about clients/patients with another practitioner in an environment that is safe and confidential.

Another practice of Circle Process includes “conscious self-monitoring.” This is a reminder to share the Circle. It involves acknowledging that everyone has something important to impart to the Circle. “It’s not about one person doing all the talking and looking smart, nor people withholding thoughts and ideas” (TN member #1). Some members have noted that Circle Process can be challenging if a person is an introvert, but many added a common sentiment that the group connection allows for a safe container in which people tend to feel more comfortable expressing themselves. TN Circle feels like “group therapy.” “There are dominant players in Circle . . . but there’s the recognition that you’ve got your opinion and I’ve got my opinion . . . ” There’s a democratic process allowing everyone a voice. Though the reality is that “there’s a lot of chatter outside the Circle via personal conversations and emails” (TN member #6).
One MD who began working at True North since its inception, and who also works on staff at two area hospitals, told me he found Circle Process to be “initially difficult.” “It was a real challenge for me to deal with Circle Process. It felt like a support group for some very right-brained and sensitive, intuitive people – most of whom were women.” He felt impatient with the slow decision-making process and extended time needed to accomplish anything. But with time he began to appreciate its benefits, including “the checking in that honors and helps engage people coming from their different places and the rededication to a higher cause than just getting through our to-do list of the day” (TN member #7). Another male TN member noted that “you have to pull teeth to get a group of male physicians to talk about the stuff that we talk about as a group. The concept of ‘checking-in’ wouldn’t happen in a male-dominated group. . . it’s exciting and makes us personally closer. It allows for some vulnerability, and some exposure to soft parts that you would never see in a traditional, hierarchical, male-dominated group” (TN member #8).

Upon asking TN members whether the “emotional intelligence” of prospective applicants was evaluated as well as their professional proficiency, I received an array of responses to the affirmative. One TN member said that a person’s “heart-centeredness is a very important part of whether we ask someone to join us, in addition to their competence” (TN member #1). True North has turned away applicants who were competent, but did not appear to fit in with their mission and process. This avoided the struggle involved with integrating new members who had a lot of years of experience, but who were steadfast in the “Old Model/Old World” conventions of health care (TN member #9).
Typically an applicant meets with the TN Medical Director who provides background on the history of True North, Circle Process, and the time involved to see if he or she is comfortable with this requirement. The applicant often has dinner with some of the TN members, submits their credentialing package, and then sits in on a TN Circle to see if it is “a good fit on both ends” (TN member #9). Interviewees cited a few cases where a practitioner was hired who did not attend Circles or did not fit in with the goal of Circle, i.e. someone who “stayed in their head.” These individuals eventually left True North. One TN member humorously told me that when she was first hired and told about Circle Process, she asked the Executive Director if she could wear a suit, and if she was going to have to sit on the floor. The answers were a respective “yes” and “no” (TN member #10).

Circle Process allows for conflict to be worked out in a healthy way rather than “the typical process” practiced in most workplaces where “conflict gets pushed underground” or people are denigrated for their viewpoint, or opinions are expressed in an aggressive, attacking manner. Thus “it’s easier to be at ease and allows for being more heart-centered instead of being in a frenetic head space” (TN member #11). There was more than one instance when discussion became heated in TN Circle, for example, discussions regarding office sexual harassment, personnel issues, insurance, or financial instability. In such moments when one could feel the tension and frustration begin to rise, a member would step to the middle of the Circle and ring the Tibetan chimes, calling for members to stop and take a deep breath before proceeding. Of course, it would be remiss not to mention the many moments of light-hearted humor. For example, in one of the TN Circles, the “Annual Pineapple Award” (literally a fresh pineapple) was presented.
to a recent TN member who was viewed as a “welcome addition to the staff.” Ad hoc comments from members included: “Just don’t leave it on your desk for a year” followed by “They make good pina coladas that you can share with your colleagues.”

The two most common concerns cited with respect to Circle Process were: (1) time commitment, and (2) hierarchy. With respect to the second concern, in various interviews, TN members acknowledged that some degree of uneven distribution of power exists at True North, that it is not a completely egalitarian operation. Some noted this is in part due to the philosophy of the Executive Director at the helm, and furthermore that the practice of Circle Process “is still evolving” (TN member #1). As an example, in the early stages of its practice at the Council, members added a new twist to the practice of consensus described in Baldwin’s text. Recognizing that many attendees came and went, and that sometimes someone might show up and vote “no” and never return, the practice of “consensus minus one” was adopted to provide a sort of buffer to fleeting participation in the Circle. As Kathryn Landon-Malone noted to me, “It’s not that we just ignore it, we really honor that ‘no’ vote, but we also realize that there is the possibility of someone coming in and sabotaging a situation, which happened once.”

Some TN members have previously worked in a corporate setting, thus providing some comparative insight between working in an organization that practices Circle Process versus a more conventional hierarchical system. One member stated that his experience in corporate America was “that they don’t really care what you have to say. You’re typically handed what you need to do and what you need to think, and how you need to approach the problem” instead of being asked to contribute to a collective process of creative design. This member felt that True North’s greatest strength as an
organization was the fact that “it asks everyone to participate.” In turn, when I asked this same member what was the biggest challenge that True North faces, he responded that “it’s to make this model work under the guise of capitalism” (TN member #12).

Given that efficiency is an operational mainstay of organizations in a capitalist society, Circle Process appears to counter this effort, often protracting the decision-making process and thus delaying the occurrence of outcomes. “The scuttle-butt around the hall is that Circle Process is really slow. . . it comes down to a personality clash. Some people want to mull things over longer than other people and some people want to get it done” (TN member #12). Although the extended time needed to make decisions is often cited as a difficulty of Circle Process, many members also note that it provides for more long-standing, effective decisions in the end. “It takes more time to make decisions in Circle, but the trade-off is that there’s a richness to the process that allows a more methodical approach” (TN member #2).

One instance was noted where the Circle was involved in extended deliberation because of one individual’s dissent. These are informally called “wobbles.” One TN member was concerned about allowing front desk staff to attend case conferences due to issues of practitioner–client confidentiality. Although many TN members mentioned this particular situation as especially difficult, the resultant outcome was the drafting of a set of TN ethical standards that surpassed the later requirements of HIPAA. Thus when HIPAA was enacted, TN members were already practicing a higher standard of ethics than mandated by the federal act (Bethany Hays, MD).

About two months after the new Executive Director, Thomas Dahlborg, began working at True North, I interviewed him to capture his relatively fresh perspective.
When I asked him about Circle Process, he said that he was fascinated with it, and first experienced it during his interview process. His overall view is that Circle Process requires a longer decision-making period because so many people are involved in the discussion; but implementation of a decision “is far easier and quicker” “because so many people throughout the organization were [sitting] at the table” to craft the action plan. Thus, “the decision-making process is longer, but the decision implementation period is shorter than in a standard business,”— though he has not yet calculated whether the total timeline is longer or shorter than in a standard business. He adds that “it’s worth the experiment.”

Another ongoing difficulty is True North’s dilemma as to how to include both independent practitioners who volunteer their time to participate in Circle as well as hourly paid staff. Staff may choose not to attend unless they are paid for their time while practitioners have more of a professional incentive to attend, but they do not get paid to participate. “There’s an ongoing tension there. We are constrained by the culture we live in” (TN member #9). One of the administrative staff members at True North stated that she liked the idea of Circle Process and the opportunity for everyone to provide input, but has also felt frustration when members state their opinion about issues that do not pertain to their job. She noted that at the last TN retreat, members decided that each Circle would write its charge regarding its purview of decision-making. The effort is intended to reduce unnecessary cross-over discussion. The staff member stated she appreciates the initial check-in at TN Circle that allows “getting to know people, learn personalities, and learn what’s going on with them,” but that discussion on issues should be limited to those directly involved (TN member #13).
One staff member stated that “staff and practitioners come to the Circle with very different agendas, different perspectives in terms of their day-to-day roles and squish them together, but sometimes the edges don’t line up.” She feels a better way to operate Circle Process would be for the staff and practitioners to each run their own separate Circles and then come together about once every two months to share in a greater vision, thus allowing the operational staff to deal with issues related to running the organization and practitioners to deal with health care-related issues. “When everyone is always involved in every component, it’s good from the informational perspective, but people get caught up in other things” that are not relevant to their role. The TN member also noted that while Circle Process is suppose to equalize hierarchy, the Executive Director oversees the business manager, who oversees the desk staff, so there is some degree of hierarchy within the Circle system (TN member #14).

The Medical Director addressed my question regarding concerns about hierarchy by stating that “circles in a triangle aren’t about hierarchy, but about structure . . . people aren’t placed over others, but people are charged by the Circle to do certain jobs. It doesn’t give you authority, it gives you the power of the Circle to do what you’ve been charged to do.” The Medical Director went on to note that as True North grows, the Circle may grow. Although Christina Baldwin suggests no more than twenty people in a Circle, the TN Circle “will get as big as it gets and we’ll recreate circle process to fit . . . Circle Process is self-governance for a complex, evolving system, so it can handle whatever the evolution is. I completely trust that we’ll figure out in Circle how to solve that problem” (Bethany Hays, MD).
**True North Today**

“We’re not an organization, but an organism, an evolving being” (Allie Knowlton).

When one first hears about True North Health Center, one might wonder how it got its name. The story was relayed to me by one of the founding members who stated that the Council members struggled for a period of time trying to find a name that all could agree upon. One evening at a meeting at the home of the shamanic healers (the Council’s meeting site had been moved out of Mercy Hospital when the Hospital informed them that they could no longer use on-site meeting space), a member opened a thesaurus and began looking up words related to their mission. At one point they got to the words “direction” and “compass” and then “true north” at which point the group felt a consensual resonance. Members felt the new health center was about “direction in health care” and that people needed a compass, direction, and a guide in facilitating their health care. Furthermore, the center was to be located geographically in the north. After some title research, the Council learned that “True North Health Center” was not patented and thus legally available for the taking (Bethany Hays, MD).

True North’s office space is located in a plain-looking brick building adjacent to a small number of local businesses that all border a very busy, commercialized thoroughfare, Route One, in Falmouth, Maine. Just across the street one can find a Walmart, fast food chains, and other various commercial enterprises representative of mainstream America. Yet once visitors enter the main door of the building and wind their way up an open stairway, they come to a set of glass doors through which they enter into the oasis setting of True North. The visitor check-in area is open and airy, with the Zen sound of running water in the background. Behind the check-in area is a large sunny
and spacious waiting room attended with comfy furniture, stocked bookshelves, a child’s play section, and a guest computer station. The practitioner offices are located along a gently-curving hallway that loops around with the multi-windowed nurses’ station seated in the spoke of the floor plan. When TN members procured their present quarters, they gutted the upper floor of the building, and in Circle Process fashion, group-designed their office space. Nestled at the far end of a section of hallway extending off the loop sits the shamanic healers’ office space, equipped with specially-constructed walls lined with eight inches of insulation to contain the hypnotic beat of shamanic drumming. [See Appendix L for photographs of True North.]

True North is not a licensed health center, but rather a non-profit research facility. Funding is provided in part by the Hygeia Foundation to support research on the viability of integrative holistic health care. Although there are other integrative health care centers in the country that offer complementary alternative modalities, there do not appear to be any other centers like True North that staff both Western-trained board-certified accredited physicians with various complementary healers—and none that includes resident shamanic healers.

The twenty-plus members of True North comprise three categories: (1) administrative staff, (2) alternative or complementary healers, and (3) medical practitioners. All members attend the bi-weekly TN Circle, and volunteer to sit on one or more smaller “work” circles (excepting hourly-paid staff who receive compensation for attending circles). Each circle has a mandate and is charged by the TN Circle to make decisions relevant to its mandate. The smaller circles are: Growth Circle (to address issues such as marketing); Education Circle; Research Circle; Nursing Circle; Practitioner
Circle (where Western-trained medical staff and complementary healers can share ideas and discuss case studies); Credentialing Circle; Front Desk Circle (for administrative staff); and Decision Circle (where the most significant issues are dealt with such as personnel matters). During my attendance at one of the Decision Circles, a clarification was made that TN Circle is about the participants (i.e. TN members) whereas Decision Circle is about the organization (i.e. True North Health Center).

The Executive Director is the head of the organization and works with a Board of Directors. When I asked the present Executive Director, Thomas Dahlborg, whether the Executive Director’s role fits in with the model of Circle Process, he told me that although a degree of hierarchy exists at True North, the Circle charges an individual to be a leader, so the TN Circle has charged the Executive Director to lead True North, to develop strategies, to further develop the Board, and to address the financial issues of the organization.

The first cache of money that had been fundraised for the formation of True North was used to hire an Executive Director with an MBA. Members felt that donors are less likely to donate money to doctors because they are presumed not to know much about managing money, and the Council wanted to reassure donors that they had business people onboard (TN member #9). Money is also earned through the rental of office space. In most cases, each practitioner rents office space from True North and works as

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37 In September 2005, I attended my first TN Circle, during which I witnessed a good-by ceremony to TN’s first Executive Director, Valerie Saffer. In December 2006 (midway through my ethnographic research period), a new Executive Director, Thomas Dahlborg, came onboard. It should be added that when the final candidates were up for consideration, the shamanic process was invoked informally to determine the appropriateness of the candidates. Supposedly this had a strong impact on the outcome of the final offer for the Executive Director position.
an independent health care provider in terms of their client/patient payment. The RSC (rent and service charge) fee for office space is based on how much the practitioner brings in using a three tiered system designed to create equity with respect to what practitioners earn for their services. There are three tiers: (1) MDs are at the top; (2) psychologists and nurses are second tier; and (3) complementary healers, including the shamanic healers, are at the bottom. Other forms of income for True North, besides grants, donations, and RSC fees, include the sale of supplements and other related health care products, sold in a small shop within TN’s quarters; and consulting to other organizations interested in TN’s integrative model.

At the time of this research, the medical practitioners included five board-certified MDs (including one psychiatrist); one DO; one ND; one clinical psychologist; three nurses with various areas of specialization such as midwifery and women’s issues, pediatric nursing, and mental health; and nursing support staff. All but one of the TN medical practitioners practices functional medicine – a holistic approach whereby the human body is viewed as a web of interconnected systems. Bringing human systems into balance, such as gut and hormonal function, is emphasized over pharmacology. Functional medicine became an established practice about ten years ago, but is not taught in medical schools as yet. One of the member MDs, Bethany Hays, is a contributing author to a textbook on the subject. I asked the MD who does not practice functional medicine if there was ever a conflict with collaboration with the other MDs at True North, and was told there had not been, and that he had received assurance from the outset that his medical plan would be respected (TN member #8). The alternative or
complementary healers at True North offer services in acupuncture, massage therapy, Rubenfeld Synergy, Healing Touch, life coaching, and shamanic healing.

All practitioners that join True North must go through a credentialing process first crafted by the Holistic Council at Mercy Hospital for all personnel. This process sets the bar for all practitioners, both Western-trained and alternative, regardless whether someone is an MD or a shamanic healer (Kathryn Landon-Malone, RN).

One MD who joined True North more recently noted that he had come from a “traditional, hierarchical, male-dominated [work] environment” in which finances were always the biggest issue. He found that money was not a forefront topic at True North (at the time of our interview), and attributes this in part to the fact that True North is a fairly female-predominant organization (TN member #8). However, the financial stability of True North and the individual practitioners became a more salient topic in the latter months of my ethnographic research.

True North employs a Development Director to help with fundraising, but she relayed to me that this process has been difficult because True North is perceived as a “doctor’s office’ rather than a research non-profit.” People tend to donate money for a cause, “a tactical idea, such as saving the environment, but we’re also a mission. . . . I liken us to a political campaign. We’re a change agent.” Other difficulties include the fact that True North is a very young organization, and because of HIPAA, True North is not legally allowed to solicit their clients (TN member #10).

Fundraising can be a challenging task, as one TN member noted, adding that it is better to market individual practitioners rather than True North as a health center. “There’s an interesting tension internally between the complementary people and the
conventional people.” Although True North is known more for its complementary healing services, with some people not even realizing that True North has Western-trained MDs on staff, the complementary healers feel that the MDs once again get “top billing” in marketing efforts. Furthermore, the presence of shamanic healers is not a TN marketing tool for fundraising activities, as advertising the practice of shamanism “can be a liability.” “We try to support them, [but] it’s a tough balance” (TN member #10).

**Insurance**

One of the most hotly debated issues that TN members discussed during my ethnographic observation was the issue of insurance – namely, whether practitioners should accept health insurance. The Executive Director noted that the present model of health care practiced in the United States is not working for many people. An overriding question is whether to have multiple payers under a capitalist system or one payer in a socialist system. Mr. Dahlborg went on to say that medicine in America is focused on population health, using a cookie-cutter approach to treatment as a means to save money. So ultimately, people with the same disease are treated the same, e.g. a person with diabetes is a diabetic and treated as such. But at True North, every diabetic is not just another diabetic because each patient has different mental, emotional, and spiritual aspects that underlie his or her disease. Thus True North “treats the individual with the disease; *not* the disease with the individual.” Mr. Dahlborg clarified that he is not advocating a one payer system, but would like to “get the insurer out of the picture” (personal interview).

During many afternoons spent in TN Circle, TN members discussed the pros and cons of accepting medical insurance and possible creative solutions to balancing the
benefits of working within the present insurance system – and working to eliminate the negative consequences that the insurance industry impinges on a health care system. Although it appeared that TN members unanimously believe insurance compromises health care service, including such denigrators as minimizing time spent with a patient, promoting high-tech expensive treatment rather than personalized care, and creating a paper-load of bureaucracy, some TN members also argued that accepting insurance was needed to attract more patients as well as a means by which to expand the demographics of the TN clientele. During one of the TN Circles, a member noted that True North was known colloquially as “a health care boutique for the wealthy.” Over time, True North’s reputation of catering to the rich has diminished, namely because TN practitioners offer Maine Time Dollars care (an extensive statewide bartering program for services rendered) and clients have found they come in less because they receive better care (TN member #13), but TN’s clientele still represent a higher income bracket within the State of Maine’s overall economic demographics.

One practitioner stated that she struggles with the issue of accepting insurance because she hears “many people say that they would like to come to True North, but just can’t afford it” and that it is especially difficult for families seeking out primary care. But she also feels that “insurance is a really sick system” and that simply taking insurance is not the answer, “it’s not a creative model, it’s not changing health care or meeting TN’s mission” (TN member #4). Another TN practitioner finds that most of TN’s clientele are middle and upper class, and would like to see a better representation of the socioeconomic distribution in Maine, as well as greater ethnic diversity, but is also not comfortable with taking insurance, and instead would like to find other alternative
means to expand their reach of services (TN member #7). Yet another TN practitioner stated that he understands True North’s concern about taking insurance, but noted that he sees people “on the edge” in his other private practice who would not be able to see him without insurance, “so there’s a piece about [insurance] that’s not resolved within me” (TN member #11).

The debate can be viewed from the perspective of the demographics of the health center relative to the region’s overall socioeconomic data, but can also be understood from a broader cultural contextual perspective. One practitioner provided her own philosophy on attitudinal shifts in health care. She stated that she believes True North can function without insurance and still serve a wide range of demographics, but “not the same percentage of the range [of uninsured] that exists in the population.” She poses the broadview question, “Where can [our services] best be applied to change the culture?” She further questions whether health care is an entitlement and raises the concern that some people are not willing to work for their health/health care. She notes that “if you want to change behaviors that affect people’s health, you need to go after the people that people want to be like,” instilling a “cultural trickle down.” She cited the example that when rich women started breastfeeding, more poor women started to do so. “Given that I can’t take care of everyone, I have to ask where I can push on the system and get the most change to happen. I’m not sure pushing on the poor makes any change happen. It’s been a black hole in health care” (TN member #9).

Some TN members were clearly opposed to accepting insurance due to their estimation that it limits provision of high level care. Within the “medical–industrial–complex” there are “a lot of people making money off the practitioner–patient
relationship” and while insurance companies cover expenses for such things as medications, surgery, and high-tech care, they are less likely to cover costs for preventative care, lifestyle modifications, and emotional–spiritual healing. This practitioner went on to say that she feels her relationships with her patients is much different without the use of insurance. “The patients are more committed and feel more empowered when they pay for the service themselves and the practitioner has more of an incentive to do their best” (TN member #2). Another TN practitioner expressed his appreciation of being able to listen to the patient and use his intuitive assessment skills, rather than listening to insurance companies. He talked about his previous experience working at a conventional health care clinic in another community in Maine where he was required to practice the standard “rush through diagnosis and treatment and document lots of problems to get more insurance payback, otherwise known as ‘churning and burning’” (TN member #6).

The shamanic healers do not accept insurance because they prefer not to deal with insurance companies and insurance typically does not cover shamanic healing (although it was noted that there was one isolated instance in which a TN client submitted a bill to their insurance company for their services and received reimbursement). Insurance coverage for shamanic healing also would most likely require shamanic practitioners to be certified. Evie and Allie (in unison) expressed the feeling that this would be a “Big Mistake!” “Giving the State license to tell you how to practice is problematic. It would be hard to reconcile mandates by the state and by spirit that might conflict” (Allie Knowlton).

One TN practitioner argues the dialectical opposite, strongly advocating that True
North move toward accepting insurance. This practitioner argues that True North’s biggest challenge is financial stability and the limited income earned by practicing physicians. He predicted there will be “a mass exodus” of practitioners at True North if the situation is not remedied. He went on to point out that a practice only employed by “wealthy practitioners is unrealistic, and not really healthy.” When he moved his practice to True North, he told me he had anticipated a large number of his previous 2,000 patients would follow him, but because he can no longer accept insurance, he lost many of them—as well as $30,000 in income during his first year working there. “We have to blend the True North culture and the commitment of the ‘founding mothers’ with the reality of being economically viable.” “There are a huge number of people out there who want to come through the door—I hear it all the time—but right now they feel there’s a barrier they can’t overcome because their particular insurance is not accepted” (TN member #8).

Clearly, the issue of whether to accept health insurance is one of the greatest dilemmas facing True North. Attempting to turn the health care system in the United States toward a new direction in the face of capitalistic headwinds has been True North’s greatest challenge. As was seen in the previous chapter, the debate among individual Western-trained health care practitioners who have adopted shamanic techniques into their practices also instills intense consternation. Although it is beyond the scope of this dissertation to provide an economic policy analysis surrounding this debate, it raises the criticality of our economic system’s influence upon the provision of health care in the United States. More on this matter will be discussed in chapter 7.
The Future

During attendance at my last TN Circle, I probably observed the most stressful gathering I experienced in the nine months of my ethnographic research. There was much discussion about the difficult financial circumstances that True North faced, and it was clear that most members were disheartened by their situation. As members sometimes noted in one-on-one interviews with me, as well as in Circles, they faced a very significant challenge in attempting to create a new model of health care amidst a failing system steeped in capitalistic corporate greed. As was noted in one Decision Circle I attended, all the TN practitioners were suffering financially to some degree from the present TN model. One member asked the Circle in despair, “What happens when someone is dying on the vine?” referring to their inability to pay their RSC fee because of financial hardship (TN member #4).

Over the course of a number of Circles, the new Executive Director dove in with statistical flair to present the members with charts of various quantitative analyses on such debates as profit earned with and without insurance, overhead per patient relative to TN revenue, marketing costs per practitioner relative to national averages, and the like. He even broached the subject of a cost analysis on Circle Process, asking whether the practice was worth the expenditure. (It should be noted that near the end of my research period, the Executive Director relayed to me one-on-one that TN members needed to take a harder look at the cost of Circle Process and determine whether it is truly more efficient in the long-run as many people have claimed, adding that some large donors had held off making donations because of their concern that Circle Process inhibits True North from making clearcut decisions and putting them into action.) In response to the Director’s
query to the Circle, a few members responded that it would be unacceptable—or impossible—to put a price tag on the value of Circle Process. When someone made the comment that True North needed to “walk its talk,” the Director asked the group “What’s the walk? Is it to revolutionize health care, or implement Circle process, or . . . ?” Thus the mission of True North was broached for greater definition, further refinement.

The Executive Director told the members that the Board of Directors was asking True North to move toward breaking even financially within the next three years. Some of the ideas to increase revenue that had been discussed in recent TN Circles included: recruiting more physicians who would pay the tier one (i.e. highest) RSC fee, increasing patient/client load; increasing internal referrals and collaborative cases, developing new marketing strategies for practitioner support groups and workshops, offering more ancillary services such as lab work, x-rays, MRIs, mammograms, etc. (a high profit margin for most health care centers), and developing creative alternatives to accepting insurance outright, such as working with small, local businesses to offer employee health care programs.

The Medical Director noted that insurance companies “may be a sinking ship in five to ten years – and therefore True North needs to create its own ship” (Bethany Hays, MD). Another member practitioner, while discussing the financial stresses each member faces by working at True North, remarked, “That’s the price of being a pilgrim” (TN member #4).

True North Health Center faces a daunting task ahead to stay (financially) afloat. Can this organization truly uphold its proclaimed mission to “change the course of health care in America” while maneuvering in a sea of capitalism? One can only hope.
Pilgrims with vision and diligence have successfully founded new frontiers before, but not without facing adversity.

The next chapter will continue to relay ethnographic research at True North, specifically with respect to the two resident shamanic practitioners and the collaborative healing model.

**Postscript**

The formal period of ethnographic data collection at True North ended in June 2006; however, a final meeting with TN’s Executive Director occurred in June 2008 to assure that the information in this chapter is factually accurate and that no HIPAA violations were incurred in relaying any patient/client-related information. During the meeting, Executive Director Thomas Dahlborg also updated me on some of the functions of True North.

As of June 15, 2008, True North supports nineteen practitioners in-house; and has established an affiliate program in which area practitioners have a working relationship with True North and attend the TN Circle, but do not rent office space on-site. Affiliate practitioners are also required to practice Circle Process at their own practices.

True North has also experienced double-digit growth in patient visits and practitioner revenue for the last two years. True North still does not accept health insurance directly. Although TN practitioners are still concerned with limiting patient/client access to health care due to economic limitations, True North has opted to extend financial support to those in need through the Maine Time Dollars program and the Reilly Fund (a separate TN account supported through private donations). Eligibility
of funds is based on low-income requirements and patient/client participation in an established health plan in which personal goals of health status are earmarked.
CHAPTER 6

SHAMANIC HEALING AT TRUE NORTH: THE COLLABORATIVE MODEL

True North Shamanic Healers

“Through spirit we got connected and learned about what we were here to do, what we were here to do together” (Allie Knowlton).

Allie Knowlton and Evelyn (Evie) Rysdyk are the two practicing shamanic healers at True North. They joined the Holistic Council at Mercy Hospital by invitation from Dr. Bethany Hays, and since that time have become active participants in the creation of True North, as well as member practitioners of the complementary practitioner staff. [see Appendix N for a photograph of Allie and Evie drumming in their shamanic garb.]

Allie worked as a pastor (and was also a pastor’s wife) and a social worker with an MSW for many years. But in 1989 she began having health problems and a medical assistant who Allie was seeing referred her to an acupuncturist who recommended that she learn to practice shamanic journeying. Allie noted that her first experience journeying “felt like I was coming home for the first time in my life – the first time I felt a sense of belonging.” She soon signed up for a five-day shamanic healing workshop with Sandra Harner (wife of Michael Harner) in New York where by chance she was assigned to be roommates with Evelyn Rysdyk. It was the beginning of a very long—and ongoing—personal and professional relationship. Allie left a lucrative private practice in Portland, Maine and moved to New York where she and Evie started a drumming circle and a shamanic healing practice. “Through spirit [via journeying] we got connected and learned about what we were here to do, what we were here to do together.”
Evie worked in advertising and as an art director. Although she had experienced chronic low-grade depression much of her life, with the onset of a heavy depression, she began “looking for a way to pull [her]self up by [her] own bootstraps.” So when she saw a flyer for a weekend workshop on shamanic journeying with Michael Harner, she signed up. Even during her first journey she experienced “the sense of potentially coming back” and stated that “one weekend [of journeying] did more for me than all the therapy I’ve ever done.” She then attended Sandra Harner’s five-day workshop where she and Allie met. “I journeyed my way out of my depression and fired my therapist. It was like getting plugged back into the wall.”

Allie and Evie then attended a three-year apprenticeship facilitated by Michael Harner and Sandra Ingerman, further honing their shamanic skills. During a journey their spirit guides told them to develop a shamanic community on the East Coast (given Michael Harner had relocated to the West Coast) and so they moved to Maine and opened “Spirit Passages” where they began to offer shamanic healing services out of their home, host weekly drumming circles, and teach classes and run extended trainings.

When they were first invited to join the Holistic Council at Mercy Hospital, Evie stated that they were not sure whether a Catholic Hospital would be accepting of two shamanic healers, but “Spirit” encouraged them to stay, and they did. They even became the first members of True North to be officially credentialed. This involved submission of documents regarding their education and training, and a large set of articles on shamanic healing research. In addition, Allie and Evie held a workshop for TN members on how to journey and connect with their own spirit guides, and in turn the TN members were able to journey to their own spirit guides to “check out” Allie and Evie.
I asked Allie and Evie if they felt any resistance from some of the TN Western-trained medical staff. They said they did not, because “[TN members] knew us as people and we shared our modality with them so they could experience it for themselves” (Allie). However, they noted that early on there was some “tittering” around the mention of “power animals,” but it soon passed. “Once they realized that we didn’t take ourselves seriously—but took the work seriously—they were fine” (Evie). “Other True North members realized that we weren’t threatening and weren’t saying that our modality is best, but just a different way of contributing to the healing process” (Allie). Although other people, including other members of True North, often refer to Allie and Evie as ‘the shamans’ [one member even incorrectly pluralizing the term as ‘the shamen’], when I asked them how they refer to themselves, Evie answered “shamanic practitioners, ‘shaman’ is a tribal designation.”

When I asked what their concept of healing is, Allie answered that it is about partnership with Spirit, both for the practitioner and the patient. Evie added that it is about helping people find a “re-connection with Spirit.” “Everybody on this continent is a displaced person, whether you came here because of the Irish potato famine or you couldn’t get good farmland back in Europe, or you came here in the belly of a slaveship, or you were moved to a reservation. Most people are displaced or disconnected from that larger whole.” Healing is “one person at a time, guiding them closer to that greater whole. Sometimes we do a piece, sometimes we walk with them the whole way. This is when the miracles start to happen. They start to get excited about life.”

One of the unique aspects of Allie and Evie’s shamanic work is that they practice together as a team. Typically shamanic practitioners/shamans work solo (with respect to
human healers), both in Western settings and traditional cultures. When Allie and Evie are working together, Allie usually focuses on the client, often doing the hands-on work, while Evie focuses on the spirit connection and conducts the rattling and drumming – though the split is not exacting. Allie stated that “we work together antiphonally.” Evie added that “there’s a collaboration with each other, with Spirit, with the client, and client with Spirit.”

The cost to receive a shamanic healing session with Allie and Evie is $80 per hour for the two of them, with an average session running two hours. Evie noted that all the True North practitioners allocate ten percent of their services for “fee free service” or “Time Dollars” and that for many of them, the percentage is higher. “If they can’t pay, they get in to see us anyway. If you’re really following Spirit, you have to treat someone whether or not they can pay you. You have to figure out some way to serve that person.”

**Collaboration between Western-Trained Practitioners and the Shamanic Healers**

“Take two power animals and call me in the morning” (Evie).

When I asked Allie and Evie about how they use the collaborative model at True North, they stated that clients often work with them to address spiritual issues, and work with the MDs and RNs to address the physical concerns. “It fits with the functional medicine protocol [practiced by most of the TN physicians] because often physical problems are due to spiritual issues” (Evie). When I asked them about how often a client might first see an allopathic practitioner versus seeing them first, Evie thought it was about “fifty–fifty” when there was a collaborative process, but noted that sometimes clients only see one practitioner.
During my interviews with each of the TN practitioners, I asked them about referrals and collaborative experiences with Allie and Evie with respect to patient/client\(^{38}\) treatment. I received an array of responses, but in almost every interview, practitioners had at least referred some of their patients/clients to Allie and Evie, even if they had not engaged in actual collaboration of treatment. And in turn, Allie and Evie frequently refer their clients to other TN practitioners. All working under the same roof certainly enhances the referral/collaborative process, but even more important is the fact that the TN practitioners have strong working relationships, much of it developed through Circle Process. One practitioner admitted that she had heard of Allie and Evie long before the formation of the Holistic Council, and that she was “kinda scared of them,” but now views them as valuable members of True North (TN member #2).

One MD stated that when she meets with a patient, if she feels they need other healing modalities, she often will present them with a “smorgasbord” of healing options. When I asked what might prompt her to suggest the shamanic healers, she stated that she often looks for “patients that have a sense that their problem has a spiritual dimension to it that they would like to explore and their church training isn’t antithetical to taking a shamanic approach.” In one case, a patient with an illness described the loss of herself through various traumas that she had experienced. The MD thought to herself “soul loss” and suggested that the patient see the shamanic healers who could help her retrieve lost

\(^{38}\) While meeting with the Education Director, I asked about the nomenclature used by TN members to refer to their clientele. I was told that most of the medical staff use the standard term, “patient,” complementary healers use “client” or “person on the table,” but her personal preference is “guest.” For the sake of brevity, this document will use the standard terms “patient” or “client” (Susan Fekety, RN).
parts of herself. The patient followed her doctor’s advice and reportedly had a positive experience (TN member #9).

Examples of reasons other practitioners might refer patients/clients to Allie and Evie included an expression of feeling stuck or experiencing extended grief, lack of direction, or a situation where they have “some kind of trauma lodged in their cells and they need ‘shaking up’” (TN member #15); or they are “stuck in their logical brain” (TN member #3). Other reasons included a patient/client who appears to have a strong spiritual orientation or connection to Native American spirituality; or a strong connection to animals and nature or they are into stories or dreams. Yet one practitioner added that although she refers patients to Allie and Evie for some of the reasons just stated, she admitted that she does not refer as many patients to Allie and Evie as other TN practitioners because “shamanism is still very alternative” (TN member #3).

Concerns regarding a patient/client’s religious background appeared to be of greatest concern to practitioners, with many noting their attempt to avoid offending anyone who might view shamanic healing as a subversive activity. One practitioner found that individuals with “strong” Christian backgrounds react with concern that “you’re really inviting the devil in” (TN member #11). Another practitioner stated that she avoids mentioning shamanic healing to her clients who are Jehovah Witnesses; “‘shamanic’ sounds like ‘satanic’ to some” (TN member #1). One of the MDs described a situation where she met with a long-term patient who was a single parent dealing with depression, during which time she suggested an array of healing services at True North, including shamanic healing. Soon after the patient left the MD a phone message thanking her for her years of care, but stated that she needed conventional medicine and
drugs. The MD never saw this patient again, noting that the circumstance was upsetting, but a lesson in realizing that “the challenge of healing is to not only know what the patient needs, but how to get them there” (TN member #9).

On the other hand, another practitioner stated that she finds most of her clients are open to the fact that True North offers shamanic healing, explaining that many of the people who walk through the doors of True North are already open to something different because either “conventional medicine didn’t work for them, or they already have an alternative bent” (TN member #4).

As practitioners join True North, they have the opportunity to receive a complementary session of each other’s modality; however, not all the practitioners had received a shamanic healing due to time limitations or in some cases, due to a sense of reservation. One of the medical practitioners stated he was not very familiar with Allie and Evie’s work and had not had a complementary session with them as yet, but did sit in on a session with one of their patients. The practitioner stated it was a very new experience for him and that it “almost smacked of religion;” however, he felt the patient “got a lot out of it” and would be likely to recommend shamanic healing to patients that brought up issues of spirituality or were dealing with something “they can’t quite put their finger on” (TN member #6).

In my interviews I also asked each practitioner how they described “shamanic healing” to their patients/clients. A common response was that each practitioner attempted to use descriptors that would likely be understandable to their patient/client, thus it varied from one individual to the next. One TN member provided an example phrase: “a very unique form of psychotherapy that would allow you to use your
imagination,” but acknowledging that Allie and Evie have taken affront with the notion of “imagination” (TN member #9). Another practitioner said that she tells clients that people gather information from different sources and that “teachers show up in different forms whether they be Jesus or the Virgin Mary or an animal” (TN member #2).

**Case Examples**

When I broached the question of actual collaborative work between a practitioner and Allie and Evie, practitioners would often tell me they knew there had been cases, but often could not remember the particular situation. Practitioners also have to be very conscious of HIPAA rules, thus maintaining full anonymity regarding any patient/client information. For those two reasons, the number of collaborative cases that I was able to obtain information about is somewhat less than what I had hoped. Furthermore, one practitioner stated that the collaborative process “doesn’t take place as much as it should, or could,” in part, because practitioners work at True North on a part-time basis. But she added that some beneficial collaboration *has* taken place (TN member #3).

TN practitioners believe that in some cases, a patient/client potentially may benefit from the synergy of physical treatment combined with emotional/spiritual healing of some sort. The combination may in some way assist the alleviation of symptoms or cure their medical condition, while in other situations it may allow the patient/client to shift their frame of mind, thus allowing them to cope better with their condition on an emotional level. One practitioner who told me she has collaborated with Allie and Evie on a number of clients, found that following a shamanic healing, “they often return with a new perspective and appear emotionally stronger” (TN member #1).
One MD described a case regarding a patient they had seen for three years, suffering from chronic pain. After the patient also began seeing Allie and Evie, through the shamanic healing process, the patient realized that her healing was not going to come from prescribed medicine, but through personal healing that would then allow her to better control her pain. The patient continues to work with both the MD and Allie and Evie (TN member #3). Another MD, who often treats cancer patients, mentioned a patient who experienced a power animal retrieval in a session with Allie and Evie. The MD felt that the session benefited the cancer patient by helping him “accept who he is a little more” and reducing his anxiety and depression “living in his own skin” (TN member #7).

Another example involved a practitioner who had been seeing a patient for three years, when the patient decided to have a shamanic healing session with Allie and Evie. During the session one of her power animals was retrieved. The practitioner saw the patient afterwards and noted that the power animal seemed to help the patient address some work issues that had been causing the patient a great deal of stress (TN member #2). Many practitioners made reference to a particular patient/client who came from another part of the country because she could not find the kind of care she wanted near her home. She spent two months living in a hotel while seeing four or five TN practitioners, both MDs and complementary healers that included Allie and Evie.

Below is a synthesis of three more accounts of collaborative healing based on interviews with the different practitioners involved:

(1) A woman in her early twenties was brought to True North by her parents to see a psychiatrist. The patient had been traveling overseas to enhance her meditation
practice, and had to be escorted back to the United States by her parents after she experienced an emotional breakdown. She could barely speak and was trembling and talking to entities not physically present – purportedly classic symptoms of paranoid schizophrenia. But the psychiatrist realized there was something else going on, and after putting her on medication that seemed ineffective, he asked the patient if he could ask Allie and Evie to do a five minute check-in based on the patient’s name. The patient agreed and Allie and Evie determined that shamanic work might be helpful, so with the parents’ approval, the patient went to see them for a session. Allie and Evie did a journey and found the client was full of intrusions, “like Swiss cheese,” concluding this was due to the client’s unguided personal spiritual work that attracted a number of possessions. Allie and Evie “sealed up” the client to help her feel boundaried (though the client was not immediately able to disengage from attracting unwanted spirits) and told her she now had some protection. The psychiatrist found her condition to be much improved when he next saw her.

The next time she showed up at True North, she could hold a conversation. Even other TN staff who interacted with her noticed an improvement in her condition. One of the new nurses at True North told me she was amazed that someone with classic Schizophrenia/Paranoia would be sent to see Allie and Evie, but when the nurse saw the woman again, she was amazed at the degree of improvement (TN member #16). Allie and Evie then referred the client to a TN practitioner who taught meditation because they could see that the woman needed to stay in her body, and journeying was not the best approach for accomplishing that goal. In total, the client saw five different TN practitioners, both Western-trained and complementary, and within a month she went
from an almost catatonic state to a high functioning level, and was able to find a job and begin working. It should be noted that the parents of the client also had their daughter receive medical examinations such as MRIs and CAT scans to rule out any organic or physiological problems.

(2) Allie and Evie were seeing someone who was receiving their last round of chemotherapy. They observed that although the woman said she did not want to die, “she didn’t really know how to live” – she had always lived to take care of others rather than for what pleased herself (i.e. “she had no circuits for this”). Journey work helped her break through her limited approach to life. The question they asked her was “How can we help support you to really live while you’re here?” Allie and Evie conducted a soul retrieval, bringing back a large circle of children who showed the client how to live in joy and passion. According to the attending MD, the shamanic work provided additional spiritual and emotional support for the patient during her medical cancer treatments.

(3) A TN energy worker referred a client to Allie and Evie who had been on disability for twelve years due to headaches. The energy worker felt that she had done all she could for the client. At the time of the interviews, Allie and Evie had been working with this client for two years, facilitating shamanic techniques such as journeying, extractions, and soul retrievals. Allie and Evie reported that the client’s pain level has dramatically dropped and she is now getting ready to return to her job. The client recently had a hip replacement and lost a close family member, but even under this stress she was able to remain grounded – considered by her health care practitioners to be a testament in itself to the healing process.

Medical practitioner collaboration with Allie and Evie works in both directions.
with respect to referrals. Not only do Western-trained practitioners refer patients to Allie and Evie for spiritual work, but often Allie and Evie will see a client and then refer them to a medical practitioner for treatment. In other words, treatment not only may involve a Western-trained practitioner’s understanding of the benefit of emotional/spiritual support to enhance the organic healing process, but at times Allie and Evie’s shamanic guides or teachers have advised a client to seek out medical care rather than solely rely on spiritual support. Thus even the guides with whom the shamanic healers work are “attuned” to both approaches.

One case involved a client who was more interested in seeking out spiritual healing for their emotional problems, but during a shamanic healing session, was told by Allie and Evie (based upon their journey work with their guides), that the client needed a form of biomedical treatment, namely pharmaceutical drugs. Another case involved a client who felt that they were being attacked by malevolent spirits, but in a session with the shamanic healers, the guides informed Allie and Evie that the patient was not being attacked, but instead, needed serious medications. The client had not wanted to consider taking pharmaceutical drugs for their condition, but following the shamanic journey work, agreed to see the TN psychiatrist. It turned out that the client was diagnosed with a case of paranoia. The psychiatrist noted other cases as well where patients were informed by Allie and Evie that they needed medication, even when the patient themselves was more interested in a spiritual approach to healing (TN member #11). Other practitioners cited cases where Allie and Evie referred patients to them because their shamanic guides relayed the client’s need for medical attention, including issues such as hormone or other biochemical imbalances, nutritional counseling, or screening for a particular disease.
Allie noted that sometimes when they talk/meet with a client, they realize through journey work that the person may first need psychological counseling rather than shamanic healing; or the client may first need medical attention. For instance, they often see clients whose adrenal systems are “shot” and sometimes Allie and Evie receive the message from Spirit that the person first needs to get their physical body in better shape before doing the deeper spiritual work/soul retrieval. Other times the client may be helped by first doing some soul retrieval work before moving on to receive physical/emotional therapy. “It just depends on the individual’s circumstances.” One client came to them who had herpes, but was too embarrassed to go to a physician for treatment. Allie and Evie were able to encourage the client to seek medical treatment from a physician.

During my interview with Allie and Evie, I asked them if there ever has been a situation where there was a conflict between an allopathic practitioner’s diagnosis or treatment recommendations and their own evaluation. Evie noted that it is not so much a matter of a conflict, but different perspectives, and different lenses of examination, e.g. spiritual, emotional, physical. “You can work back and forth and give referrals because there’s so much mutual respect between the TN practitioners. They’re so skilled in their different disciplines that it’s more like different perspectives, not a conflict.” Allie added that another benefit of working collaboratively at True North is that “we can even introduce clients to different practitioners as we’re walking down the hall.”

Allie and Evie mentioned that practicing different modalities sometimes creates a challenge with respect to communicating their different perspectives. In case presentations, MDs sometimes speak in ‘doctorease’ that would need further explanation,
while conversely, the MDs sometimes have to ask one of the alternative healers to explain their terminology, such as the condition of ‘spirit possession.’ During my period of research, it became obvious that at least some of the concepts of shamanic practices had more readily seeped into the vernacular of True North. During one of the check-ins at a TN Circle, a member announced that while snorkeling on vacation in Hawaii, she encountered a new “power animal” – a sea turtle (TN member #17).

Allie and Evie share clients with some of the other complementary healers as well as the Western-trained practitioners. One of the TN complementary healers who does a lot of “energy work” noted that she has collaborated on clients with Allie and Evie as well as seeking out advice about clients. In one case she worked with a client who felt the spirit of a dead baby inside himself that he identified as his mother’s spirit. The practitioner was able to discuss the situation with Allie and Evie, stating that it was helpful to be able to have a resource to consult with “about the ‘wild’ things going on” (TN member #17). I followed up with the question of whether there was too much overlap or competition between the complementary healers. I was told by one of the complementary healers that True North’s goal was to offer enough variety in healing modalities so that “there’s something for everyone.” The interviewee added that True North would not hire someone who does similar work to a practitioner already working at the health center, or who teaches similar classes – unless it was approved by TN members via Circle Process (TN member #17). Another complementary healer responded to this question stating that “We’re all doing the same work behind different doors . . . I just think the hats are different that the people are wearing while doing this same work. So
that’s kind of a benefit for the outside world that they can go behind the door with the person with the hat on that works best for them” (TN member #15).

Having been informed that sometimes practitioners informally seek out advice about a patient/client from another practitioner, including Allie and Evie journeying on a particular case for another practitioner, I asked if any sort of payment was requested in these consultations. I was told that this is not the case, that they are informal exchanges (TN member #5). Due to the relational building among colleagues at True North through Circle Process, this kind of informal collaborative exchange of information between practitioners appears to take place comfortably for the benefit of the patients and clients. As well, some of the practitioners exchange services with each other for their personal health and healing.

One of the MDs relayed her experience working with Allie and Evie. She began by telling me how she entered medical school with an open heart and a lot of enthusiasm, but found that memorization and critical thinking were the skills most valued. She found that to survive residency, she had to close her heart, and later realized that she had experienced “a slow erosion” of herself. When she first began working at True North, she emphasized rational thinking and her diagnostic skills, “operating from the neck up” which she found to be “stressful, very isolating, and very tiring.” Through her introduction to and exploration of personal shamanic healing with Allie and Evie, she has been able to engender greater intuition, empathy, and a more humorful approach to her patients. During one shamanic healing session with Allie and Evie, she experienced three soul retrievals, thus allowing her to bring her “full self” into her practice. “I’m now more able to fuse my knowledge of physiology, biology, and medicine with knowledge of why
people, sometimes not knowingly, choose to suffer. I feel like I’m connecting with my patients from a more heart-centered place” (TN member #3).

Social Responses to Working with Shamanic Healers

During each interview I asked TN members what kind of responses they received from colleagues, family, and friends if and when they mentioned that they worked at a health care center that included shamanic healing services. I received an array of responses.

When I asked the Executive Director if he mentions the shamanic healers when talking about True North, he responded that “it’s one of the first things I mention.” He is also looking for ways to qualitatively measure patients’ experiences and health outcomes with shamanic healing. “I want to be able to spread the word with data that shamanism works and here’s how we know it.” He would like to conduct this analysis for the other modalities of treatment offered at True North as well (Thomas Dahlborg).

One of the TN practitioners noted that some of her colleagues “think it’s weird that True North has shamans.” When I asked if she felt her colleagues viewed her with less respect because of this arrangement, she responded in a telling statement about her experience with the medical community as a whole:

I’m so impervious to [feelings of disrespect] because I have always been seen as an outsider. From the moment I walked into medical school, I was a woman, so I wasn’t a real doctor, I was a woman doctor. And then I did midwifery, so I wasn’t a real obstetrician, I did squatting births. And then I wasn’t a real doctor because I did holistic medicine; I joined the American Holistic Medical Association. And now I’m not a real doctor because I practice functional medicine (TN member #9).

Another MD says she sometimes mentions that she works at a health care center that offers shamanic healing, though tries to gauge whether the listener is “ready to hear
about shamanism and changing health care.” She noted that some respond with interest, others with a chuckle—usually a range of “curiosity to astonishment” (TN member #3).

One MD who arrived at True North from a more conventional professional background noted that many of his professional colleagues are more rigid about the value of Western medicine relative to alternative practices, and when he first told them he was going to work at True North, he got responses such as “‘Why in the world are you going over there [True North]? Those people are weird.’” But as True North’s reputation has grown, he finds his more conventional colleagues have shifted their question to a more genuine greeting of “‘How are things going over there?’” (TN member #8).

A nurse practitioner told me that when she lists the range of services offered by True North, she always mentions the fact that they have shamanic healers. She sees it as an advantage and a selling point rather than a liability given the kind of client population that True North is trying to attract. Her mention of shamanic healers to family and friends has always drawn positive responses; but notes that in particular, midwives tend to be a fairly liberal group (TN member #2).

One complementary practitioner stated that when she mentioned that True North offered shamanic healing, most people were both surprised and impressed. However, when she mentioned this to Western-trained health care practitioners, responses were mixed, though “silence” was more the norm in lieu of negative comments (TN member #15).

Another complementary practitioner told me that when she mentions her collaborative work with the shamanic healers to her colleagues within her methodological field, a common response she receives is “‘You mean you really have them, they’re
allowed in?’” adding that “They all salivate. They’d all give their right arm to work in a place like this” (TN member #5).

**True North Clients**

‘I am the rest between two notes’ (recited from a line of a poem read at a friend’s memorial service). And so much of my life has been the notes, the doing, the sounding, and yet without the rest between the notes, there is no music, there is no melody, no harmony. So this is a period of my life where I’m learning about the rest between the notes, the ‘being’ rather than the ‘doing’. A big change for me (Henry).

The above quote is an excerpt from an interview with a TN client who summed up how his life has changed since he began his exploration into shamanic healing. This section focuses in particular on the results of conducting interviews with TN clients who experienced shamanic healing with the TN shamanic healers, Allie Knowlton and Evie Rysdyk.

Most of my dissertation research reflects the thoughts and experiences of health care providers who either practice shamanic healing or collaboratively work with shamanic healers. Surveying and interviewing clients who have received shamanic healing from all the practitioners that I interviewed would have been an extended effort beyond an already extensive research protocol; as well as being difficult to locate and identify. However, surveying and interviewing clients who received shamanic healings at True North presented itself as a straightforward and seemingly worthwhile task. Thus during my ethnographic tenure at True North, I provided a set of client surveys to Allie and Evie for the respondent’s easy return to me (see Appendix I for a sample of the survey). The survey does not provide any statistically valid data, in part given that I had no control as to whom actually was offered the survey in the first place, but it highlights some interesting non-statistically valid background information, and more importantly, it
provided names of individuals willing to be interviewed about their personal experience with shamanic healing at True North.

After prior review and approval of the client survey by the TN Education Director, I hand-delivered to Allie and Evie a set of 30 surveys each with an attached stamped and addressed envelope (addressed to the Department of Anthropology at UMass Amherst) on December 7, 2005. The survey clearly stated that any response was voluntary and confidential, and respondents were able to fill it out anonymously or provide their name and contact information if they were willing to participate in an interview with the lead investigator. Allie and Evie kept the blank surveys with attached envelopes in their shamanic healing office and were asked to offer a survey to all of their clients. However, no control was in place to ascertain whether all clients were offered the survey or how it was presented to them.

During my tenure at True North, I received 21 completed surveys of which six were filled out anonymously and 15 with names and contact information. Of the 15 respondents who provided their names and contact information, I was able to arrange interviews with 12 of them (scheduling limitations eliminated the other three respondents). All interviewees provided a signed Informed Consent Form either in hard copy or via email.

The survey consisted of one two-sided sheet containing seven questions asking for a “check” beside provided answer(s) or a short written answer, thus the time requirement to complete it was minimal. A tally of the 21 surveys can be summarized as follows:

Question one asked for respondents to place a check next to six provided reasons
(or fill in “other”) as to why they chose True North. All six provided answers were checked by three or more respondents, so it appears that clients choose True North for an array of reasons. Some were drawn to True North because of an advertisement or personal referral, or they wanted to see a particular practitioner. Thirteen respondents visited True North specifically because they were interested in receiving shamanic healing. Through question two, it was discerned that 16 respondents were aware that True North offered shamanic healing and that the respondents were also interested in experiencing it. Nine respondents previously had experienced some form of shamanic healing. In question three respondents were asked to list the number of shamanic healing sessions received at True North. Answers ranged from one to fifteen, although some of those interviewed revealed that they had received many more, one stating an estimate of “thirty to fifty times.”

Responses to question four indicated that 12 respondents saw only the shamanic healers at True North while the other nine saw one or more other TN practitioners as well, either complementary healers or Western-trained medical practitioners. Question five asked respondents to rate the degree of helpfulness of their shamanic healing session(s) at True North, providing a range of 1 (not at all helpful) to 5 (incredibly helpful). Nine respondents checked the highest level of 5, seven checked the next highest level of 4 (very helpful), and five respondents checked level 3 (moderately helpful). Question six asked respondents whether they would consider shamanic healing in the future to treat other physical or emotional conditions. Eighteen respondents answered with strong affirmative statements and three made statements to the effect that they would possibly consider it (i.e. a form of ‘maybe’). Question seven asked for the
respondents name and contact information if they would be willing to be interviewed. As stated before, 15 respondents did so.

Interviews with the clients ranged from approximately thirty minutes to as long as ninety minutes; four via telephone and eight in person. The interview sites included True North offices, local coffee shops, and the interviewee’s home, determined by each interviewee as to what location was most convenient and comfortable for them. All interviews were taped and transcribed; however, the surveys and all related materials are held in strict confidence by the lead investigator. Any information provided below is done so with anonymity and/or with explicit permission from the interviewee.

Interviews were open-ended with the attempt to provide a relaxed, conversational-style manner of exchange to allow shamanic healing clients a comfortable setting in which to share their stories and experiences. Each interview included a set of questions, however these were not asked in an ordered format, but rather woven into the “conversation.” Questions covered such topics as why the client chose shamanic healing, previous knowledge of and experiences with shamanic healing, his or her experiences with the shamanic healing at True North and any collaborative healing with other practitioners, and responses from others upon learning that the respondent had sought out shamanic healing (see Appendix J for a list of interview questions). Of the 12 clients who I interviewed, four were male and eight female. The age range extended from the late–twenties to the mid–sixties. The majority of clients interviewed sought out shamanic healing to address emotional/spiritual issues, though some also either included physical issues initially, or added physical conditions to their agenda once they had experienced shamanic healing. Two individuals contacted Allie and Evie to clear out unwanted
entities in their homes, both sensing (and in one case even photographing images of) the presence of uninvited energies.

As noted from the survey results, in some cases clients specifically came to True North to work with Allie and Evie, having been recommended by friends or a family member, or having seen a flyer or listing through the Time Dollar program. Others first saw another TN practitioner. Below are some of the statements made by interviewees regarding their decision to see Allie and Evie:

* One interviewee was already seeing a medical practitioner at True North, who then referred her to one of the TN complementary healers, who in turn then sent her down the hall to Allie and Evie. The interviewee noted she views Allie and Evie’s office, which sits at the end of the hall, “as the end of the line” (Faye).

* One client stated he was interested in shamanic healing because he wanted an alternative to Western medicine. He was attempting to treat a serious case of depression, but he did not want to take pharmaceutical drugs and yet he knew he needed more than just a smile and a hug from a therapist; he was “looking for something that wasn’t ‘pharmy’ or ‘huggy’” (Larry).

* After emailing photographs of ghosts in her home, and having Allie and Evie conduct a long-distance shamanic healing session, the interviewee discovered that “the most difficult spirit was finally gone.” At that point, the interviewee felt she had to meet Allie and Evie in person to pursue personal healing work (Nancy).

* One interviewee was unaware of shamanic healing until one day she entered a store called “Mystic Indian” where she had wanted to visit for months before the opportunity finally arose. While perusing the bookshelves, a book about shamanism “practically fell in [her] hands,” which she readily purchased. This prompted her to check out local listings of shamanic healers, and thus contact Allie and Evie (Inga).

* One interviewee followed the recommendation of a relative to see Allie and Evie, after having secured a primary care doctor at True North. The interviewee stated that she felt more comfortable with the idea of seeing the two shamanic healers because of their affiliation with True North; it made it feel “more legitimate” (Lorraine).

* In contrast, another interviewee knew she wanted to look more deeply at some of her spiritual issues. However, upon coming across a brochure for Allie and
Evie, she was reluctant at first to see them because the flyer was “a little flashy, too commercial,” but she then overcame the resistance. The interviewee added that if the glossy pamphlet was an advertisement for a doctor’s office, she “wouldn’t have thought anything about it” (Tonya).

When asked about the experience(s) of shamanic healing at True North, these were some of the comments:

* One client goes back and forth between Allie and Evie and an osteopath trained in shamanism by Allie and Evie. He stated he wanted to deal with physical issues through spiritual work and continues to go back and forth between the two offices because they “have different windows” of accessing spirit. The client noted that in one circumstance, Allie and Evie retrieved some soul parts, and through physical manipulation, the osteopath helped fully integrate them back into the client (Niles).

* One interviewee stated that she does not differentiate between physical and emotional problems. She went to Alllie and Evie to deal with both because “they are one and the same.” In one of her sessions with Allie and Evie (of which she had many), she asked for healing assistance from a spirit for an organ recovering from cancer. The interviewee stated that the spirit has shown up repeatedly in her journeys to provide physical healing to the area. The interviewee has also received collaborative spiritual work for specific issues between other complementary healers at True North and Allie and Evie. She added in her interview that shamanic journeying “is more fun than IMAX” (Marcy).

* Another client told of a session with Allie and Evie in which a soul retrieval was performed for her gall bladder. [The interviewee noted to me that soul retrievals can even be done for particular organs.] Although a doctor had told her eight years ago that she should make plans to have her gall bladder removed within five years, she gloated that her gall bladder is still healthily intact (Inga).

* One interviewee stated that specifically because of shamanic healing work, “I think I at least try to listen more to my body, to myself, I try to look at things with more compassion . . . “ (Ernest).

* Another interviewee stated that he has found his sessions with Allie and Evie to be “so rich,” having received healing support both with physical conditions, including the after-effects of a heart operation and negative reactions to pharmaceutical drugs, as well as emotional issues such as deep scars from childhood. The interviewee also noted that shamanic work has helped him balance his right and left brains, having previously favored the latter (Henry).

* A client stated that she has dealt with issues in one shamanic healing session that took years to address in talk therapy. She quickly stopped seeing her
therapist after she began seeing Allie and Evie (Inga).

* One client traveled several miles out of state to see Allie and Evie because of a difficult situation with her marriage. She noted that while the shamanic healing has not changed her relationship with her husband, it has changed her. “It has taken me completely out of the victim role; it’s given me my self back. Shamanic work gave me the joy back and that was worth every penny and the trip” (Lydia).

* An interviewee who has been seeing a naturopath while seeing Allie and Evie noted that she has been able to guide her naturopath to specific (and accurate) acupressure points through information relayed to her from her shamanic guides (Tonya).

* Upon sleeping in a newly-built home, one interviewee told of the respiratory problems she developed, feeling that she needed to get out of the house. Only after seeking treatment from a medical doctor at True North did she learn that she had developed Multiple-Chemical Sensitivity (MCS). But prior to making an appointment with a TN practitioner, the interviewee relayed that she had seen five doctors, including pulmonary care specialists and allergists, who knew about her living situation, but never diagnosed her with MCS and even suggested she close all the windows and run air recirculation devices. She added that one allergist told her she thought she was suffering from depression. The interviewee sarcastically remarked to me that she hadn’t felt depressed before going in to see the doctor, but felt that way after being “talked down to.”

She later began to see Allie and Evie to help clear out the toxins in her body, but also “to heal the woman who didn’t listen to her heart and intuition.” The client said she was “a big skeptic to any kind of alternative energy work” not long before experiencing shamanic healing work, but now feels that shamanic healing has helped reduce her MCS as well as increase her sensitivity to her own emotions and honor those of others (Faye).

Many stories of healing included discussion about issues with relationships.

* One interviewee mentioned that she has an adult daughter with mild retardation. Sometimes her daughter was frightened to leave the windows open during rainstorms. Only after experiencing shamanic healing and studying shamanism did the client understand that her daughter could see elemental spirits—and was afraid of the storm spirits. “I didn’t have a clue about my daughter’s spiritual experiences before working with shamanism.” She and her daughter are now much closer because of their shared experiences with the spirit world (Inga).

Given that it is extremely rare for two shamanic healers to work in tandem (in this culture or indigenous cultures), I often asked interviewees how they felt about working

with Allie and Evie together, especially for those who had previous experiences with
other shamanic healers. Many of the interviewees made similar comments regarding the fact that Allie and Evie are different personalities, but complement each other well.

“They are very different people, and they don’t always agree, but it’s not a matter of conflict but more that they work as a team to provide a broader perspective” (Tonya).

One interviewee stated that he “love[s] the way they play off each other and the way they play with me. When Allie and Evie call in their guides, I feel like all possible allies for healing are being assembled” (Henry). Another interviewee spoke of the love they radiate and stated she “couldn’t imagine anyone leaving their office and not feeling great” (Nancy).

I did not always ask clients about their relationship to the natural world, instead waiting to see if they first mentioned it, and then broaching the subject once an interviewee made some kind of reference to environmental concerns. One interviewee worked in an office for years, but after receiving shamanic healing from Allie and Evie, and then studying with them through their apprenticeship program, she left her job to allow for more time to practice shamanism. She stated that she did not have much of a relationship with the earth before pursuing shamanic healing, but now feels much more connected and attends monthly “Medicine for the Earth” circles facilitated by Allie and Evie (Inga). Another client stated that she has always had a strong connection with nature, but through her study of shamanism, including plant spirit medicine (initially with a different shamanic practitioner), she has developed some “amazing relationships with certain plants” and receives messages, teachings, and support from them (Tonya). Yet another client stated that since her illness and her shamanic healing work, she is much more aware of the natural world, and friends have told her “that she has turned into a
hippie.” She now only eats organic, is more attentive to animals, no longer uses or discharges toxic chemicals into the environment, only eats small amounts of meat, and blesses her food.” She adds that “I’ve become much more compassionate, all around” (Faye).

When I asked interviewees whether they mentioned that they had experienced shamanic healing to others, most said they had only told a few people and were very discriminating with whom they shared this information. One interviewee noted that friends were “fascinated and a little bit leery.” She likened attitudes toward shamanism today as similar to wary reactions to the idea of seeing a therapist back in the 1980s. She added that although her friends commonly look at the emotional/spiritual aspects of physical conditions, shamanism “still seems to have a stigma” (Lorraine). Another interviewee said she never had a direct negative response, but at her workplace a friend of a friend who is a “born-again” expressed worry about the other friend’s soul because she was spending time with someone who dabbled in shamanism (Inga).

One of the interviewees works at a medical research center, and when I asked if she was comfortable talking about her shamanic healing experiences with coworkers, she stated that she felt the response of coworkers would be mostly negative given that shamanism has not been scientifically proven to be effective (Lydia). One client expressed considerable wariness, telling me that she stays “very circumspect about this stuff.” She remains both private and protective about her spiritual beliefs because “I don’t want to give someone ammunition to look at me and say ‘you’re crazy, you’re a kook, you’re invalid because you’re so far out on the edge’” (Lorraine).

When I asked interviewees about whether they thought they would continue to
seek out shamanic healing, many said they would because of the many positive experiences cited above. However, some also mentioned limitations to seeking out shamanic healing at True North in the future. A common concern was the cost of the sessions. One interviewee noted that a cost of $80/hour for a shamanic healing “prevents a lot of people from exploring it given an HMO might charge twenty dollars for a shot or prescription of antibiotics” (Rita). Another interviewee said that she felt shamanic healing was expensive, but added that it is a “compacted treatment” that provides powerful and long-lasting healing (Lydia).

Yet another interviewee admonished the limitations of both cost and location, noting he had “suburbaphobia” and wanted to do shamanic work in his own environment. “Do I wanta go to Siberia to see some shaman?” No, I wanta stay in downtown Portland, I mean I know it’s not Siberia in Falmouth, but it’s not my environment, so to be healing in a foreign country as it were, maybe it’s extreme to say that, but I feel very uncomfortable in suburban settings, whether it be strip malls or half acre lots, I just don’t feel comfortable.” He continues with the statement that “I don’t think our culture is very well set up for [shamanic healing] and [True North] is still institutional. It was a nice place with blankets and a view of trees, but it’s still institutional, it’s still strip mall, asphalt, and office building and for me that lacks all sense of place and community and that’s the downside” (Larry).

One other interviewee commented about the physicality of True North, noting the façade of the building made one think “it’s an insurance company or something” but added that upon entering, “it’s like this amazing place” (Tonya). Thus cost was clearly the biggest limitation to individuals seeking out more shamanic healing at True North,
and in at least one case, it’s location.

The overall experience of hearing individuals’ stories of suffering and healing was very moving; and an honor to be a recipient of their telling. One interviewee sent me a follow-up email in which she added “A lot of stuff is coming together for me this year, spiritually and therefore creatively, as I let go of some of my fears of being true to my inner self. Speaking to you was part of that process” (Lorraine). It is always appreciative to learn that even within the scope of ethnographic research on healing, an added thread of the healing work itself sometimes ensues.

**Shamanic Healing: the Human–Environment Connection**

During my interview with Allie and Evie, I wanted to probe the question of how they defined and practiced healing, and whether it extended beyond the individual human, (e.g. animals, plants, the land). While the practice of shamanism in most other cultures involves healing the imbalance between humans and the non-human world, emphasizing the relational aspect rather than the individual, the adoption of shamanic healing in the United States has tended most often to address a person’s individual condition or circumstance.

Upon broaching this topic, I asked Allie and Evie about healing the earth, the environment. Evie stated that they mostly work with people, but that “it’s all connected. People are where it breaks down, where the system breaks down. And so in supporting people to get more in touch with themselves and reconnected to the earth, we heal the earth indirectly.” Allie and Evie work on humans, animals, buildings, and the land itself. “We don’t separate out healing the earth from other entities. We don’t treat it as its own entity.” They have taken trips to distant places such as Canada and the Arctic where they
have done shamanic healing on the land, but they also work locally. In particular, they
told me about a parcel of land in Gray, Maine where a woman had seen entities in her
home and even sent photos of them to Allie and Evie via email. Allie and Evie took on
the project and went to the property to clear unwanted spirits and balance the energies of
the land. To help calm the energy of the woman’s property, Allie and Evie advised the
owner to plant flowers around her home. It so happened that the woman had just bought
three hundred Day lilies the day before.

Evie stated that the earth contains vortices where wonderful energy is coming out
of the earth, like in Sedona, Arizona, but that there are also places where there’s “an
involution of energy that’s kind of like a drain.” While people use to be able to avoid
such places, it is more difficult now as more land gets developed and populated. Thus
these areas need some form of healing such as energetic clearing and balancing.

When Allie and Evie began offering “Medicine for the Earth” workshops, they had
trouble attracting participants. “People didn’t get it.” Once they began incorporating this
ideology and practice into their human-based workshops, then “people got it.”

“Oftentimes people can’t make that leap from tapping into their personal divinity to
shining that divinity out to heal the earth. It happens more as an organic evolution in
somebody’s process.”

They told the story of traveling to Montreal to run a workshop for a local
shamanic group, who typically traveled an hour into the countryside where they gathered

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39 A system or methodology developed by Sandra Ingerman, a well-known Western
shamanic practitioner, that offers healing both to the environment and to humans. Based
on an understanding that there is a connection between all beings, that the health of one
part of the planet will affect another, “Medicine for the Earth” offers ceremonial
techniques of transmutation to reduce toxins in the environment.
for their rituals. Allie and Evie encouraged them to work instead with the spirits of nature right where they lived. Part of their mission is to encourage people to get in touch with the sacredness of life around them. “It’s important to meet the spirits in your own neighborhood.” “We need to recognize that the sacred land is right outside our door. It [may even be] in the windowbox of your apartment building” (Evie). Evie added that about eighty percent of the time their teachers prescribe a treatment to their clients that involves going out into nature.

Allie and Evie meet with a small group of people monthly to practice “Medicine for the Earth.” Though small in numbers, the group has been meeting for over four years. But Allie noted that there are not many people wanting to do “the really hard work.” Furthermore, they recognize that working with people in a Western culture is different from those raised in more traditional indigenous societies.

We have a unique set of circumstances as practitioners in a Western culture because we have to work where our clients are, and where they are is really disconnected. We have to help them build those bridges. We’re midwifing people back into relationship with themselves, with the natural world, with creatures around them, and with other human beings. You can’t do it in the same way that you could in a tribal culture – with people who grew up that way, who live closer to the earth. We’re dealing with people who maybe are anywhere from two to eight generations of disconnection. We have a deep relationship with the spirits of place and earth, but we can’t just impose that on others. That’s not going to make any progress. That’s like some kind of dogma. But if you can midwife somebody into opening up to themselves, then it’s genuine and sustainable.

The way shamanism in this culture is evolving is to work with people where they are in this culture. So you have to take people where they are, love them where they are, and support them to get curious. And open up a little bit, a little bit, and then sometimes they’re off like great guns (Evie).

Allie and Evie closed our interview by stating that their passion is to support people in connecting with “their own spirits and guides, and their own divinity.” And
that the “hardest part of being a shamanic practitioner is to practice it every day in our lives . . . To be living consciously ‘24-7’” (Allie).

The following chapter will compare the Collaborative Model discussed in this chapter with the Individual Model discussed in chapter 4. The discussion will then turn to the broader analysis of the practice of shamanic healing techniques in a Western culture, i.e. the United States, in comparison to practices of shamanism(s) in more traditional shamanic cultures.
CHAPTER 7
ANALYSIS OF FINDINGS

Introduction

In this chapter the investigator will provide two levels of analysis, one subcultural and one cross-cultural. The first level of analysis will present a pragmatic comparison between the Individual Model and the Collaborative Model based on the qualitative data provided in chapters 4 and 6. Thus the discussion centers on comparing two different contemporary approaches to adopting shamanic healing into established health care practices within the United States. Granted, the collaborative model in this study is based on only one example. The reason for this, as stated before, is that True North is the only health center in operation to date that provides a collaborative healing approach to patients in which both shamanic healers and Western-trained health care practitioners offer conjunctive services. It’s a vanguard approach, and a model that many other health centers are interested in emulating (based on the requests for True North’s consulting services from various health centers). Thus it is a healing model well worth examining in its own right, as well as within a comparative context of other models.

The second level of analysis discusses the broader implications of practicing an ancient form of healing within the context of a “modern” society steeped in a Western paradigm of science and economy. This meta-analysis highlights the ways in which the traditional practice of shamanic healing has been altered to adapt to a Western culture, as well as ways in which Western practitioners of shamanic healing have been culturally altered by the practice and precepts of shamanism. Thus the resultant cultural adaptations
display a syncretic healing practice as well as an attitudinal and methodological shift within the biomedical culture.

**The Individual Model versus the Collaborative Model**

What appears to have the greatest effect on the practice of shamanic healing between independent shamanically-trained medical practitioners and the two non-medically trained shamanic healers at True North Health Center is the institutional backing experienced by the latter. Allie Knowlton and Evie Rysdyk played a role in the founding of True North and are established members of the health center’s team of practitioners. Although neither have degrees in a medical field, such as an MD, RN, DO, etc., they are able to practice in a much more overt and open manner than almost any of the practitioners interviewed within the Individual Model. Of the 27 individual medical practitioners interviewed, the individual most comfortable with publicly advertising her shamanic practice is the one pharmacist in the interview cohort who also leads workshops and trainings in shamanic healing and herbalism, and runs an independent healing practice.

One of the MDs who authored a book about her shamanic work (*Shaman MD* by Eve Bruce) is more open about her shamanic work in her medical practice (and has a separate shamanic healing practice), although in her interview she stated that she does not always overtly practice shamanic techniques; rather it depends on the patient’s circumstances. A small number of the rest of the individual practitioners expressed some degree of institutional support, but only one practitioner out of the 27 interviewees who works for a larger health care institution described a high degree of overt practice, and even for this medical doctor, he was selective and discreet in broaching the subject of
shamanic healing with his patients. Furthermore, the institutional support that he received was acknowledged through his allowance to bring his drum to work and hold drumming circles, and to develop a policy statement regarding alternative health care offerings where he works; but it does not involve institutional publicity of shamanic healing. Only True North Health Center advertises shamanic healing in its menu of offered services listed in its brochures and on its official website.

A small percentage of interviewees noted that they did have shamanic healing practices separate from their professional medical practices. One practitioner informed me that he works out of the same office to run his osteopathic practice as well as his shamanic healing practice, but advertises each using separate business cards. It was clear from the interviews that all 27 health care practitioners, except for the pharmacist, placed much of their professional emphasis on their medical degrees and practiced shamanic healing covertly or selectively overtly as an adjunct to their medical practice. Some lamented the fact that they felt a need to remain covert for reasons of professional status and/or legal protection, and two practitioners mentioned the possibility of leaving the medical profession in order to practice shamanic healing more readily and openly.

As was presented in chapter 4, many practitioners feared being (or were) ostracized by other members of their discipline, or even their immediate colleagues. One MD who worked in a small private practice did not even feel comfortable sharing her interest in shamanism with her medical partners. Furthermore, practitioners who fall in the lower ranks of established medical hierarchies (such as RNs and physician assistants who rank below doctors) must deal with the added concern of practicing their shamanic
skills overtly among disapproving medical superiors, as well as skeptical colleagues and patients.

The fact that Allie Knowlton and Evie Rysdyk of True North are not medical practitioners (though they both have advanced degrees in non-biomedical fields), and function outside the medical establishment—and yet work in an established health center—provides them with a unique position. They can take advantage of their medical affiliation without concerning themselves with many of the barriers and limitations that the medical establishment imposes upon its membership. Allie and Evie openly advertise their practice of shamanic healing, provide office space decorated with ritualistic objects, practice overtly using drums, rattles, and other shamanic paraphernalia, and unabashedly channel their spirit guides’ messages. Even though they sometimes work with clients who are skeptical of their craft, the client is there with an open acknowledgement (albeit not always a clear understanding) of their shamanic healing practice.

Furthermore, Allie and Evie have been able to develop a working relationship with other practitioners at True North that has fostered a collaborative and/or internal referral model of patient care. In the TN Practitioner Circle, both medical and complementary practitioners take turns presenting case studies of clients (who have granted permission to do so) to gain feedback on possible healing approaches, be they biomedical or alternative. As well, many of Allie and Evie’s clients were referred to them by another TN practitioner, and in turn, Allie and Evie often refer their clients to other TN practitioners. Upon interviewing most of the TN practitioners, it became clear that some of the medically-trained practitioners were less familiar than others, even less comfortable, with shamanic healing. However, every practitioner has the opportunity to
receive a complimentary treatment by the other TN practitioners as a way to experience different methodologies first-hand; and every practitioner has at least some exposure to the ideology of shamanic healing via discussions at various TN Circles attended by Allie and Evie. It also became clear through the interview process that Allie and Evie are not [completely] wary of Western medical approaches to healing. Allie and Evie provided examples where they recommended a client seek out medical assistance rather than (or before) seeking spiritual healing.

Another vantage point of Allie and Evie’s position at True North is the fact that the health center established a rigorous credentialing process for all member practitioners, whether they are medically-trained or complementary healers. This provides them with an enhanced credibility among their fellow practitioners as well as clients, and the broader public. TN Executive Director, Thomas Dahlborg, stated that when providing consultation to other organizations interested in replicating TN’s model, he stresses the practice of True North’s credentialing process as a key component of their success.

It should be noted that this discussion is not meant in any way to denigrate shamanic healers who are unaffiliated with a medical establishment. It is simply a case that they sit outside the scope of this study that centers on the integration of Western medicine and shamanic healing. Non-medically-trained shamanic healers encounter their own set of constraints and prejudices in their vocational practices (though I also touched on some of the biases experienced by medical practitioners emanating from non-medically-trained healers—see chapter 4), but this is a topic to be left for a different research project.
Shamanic Healing in a Foreign Land

As has been underscored a number of times, one of the intriguing aspects of the particular form of syncretic healing that results from practicing shamanic healing techniques within a biomedical model in the Untied States is that many of the underlying tenets of each healing system are very different, sometimes even contradictory. So what results is sometimes a blending or melding of practices, but in other instances an ideological or practical adjustment of one model to better align with the other. In the case of adopting shamanic healing into Western medicine, I would argue that both hybridization (a blending of “original” practices) as well as “mutation” (i.e. reconfiguration into a new form) of cultural practices has occurred.

Although shamanism is considered the oldest form of healing and believed to have been practiced historically in most parts of the world, major movements such as Christianity, the Scientific Revolution, and Communism undercut this belief system – or at least societal condonement of its practice. Given the European influence of the United States’ founding in matters of religion, science, and economics (e.g. Protestantism, Cartesianism, and Adam Smith’s economic concept of the “invisible hand” in free market systems), the sociocultural climate in the United States has continually evolved to further emphasize principles of private property (and privacy), commodification of resources and services, and an anthropocentric view of nature and spirit. These principles contrast with more traditional or indigenous societies grounded in communalism, small-scale economics, and poly-/pantheism.
Individualism

Firstly, although the root cause of the emergence of shamanism is debated (e.g. whether purposes of hunting or healing came first), descriptions of shamanic practices usually involve a shaman working with other humans in relation to the natural and spiritual worlds, “the exemplary voyager in the intermediate realm between the human and more-than-human worlds . . . “ (Abram 1996:7). The focus is never on self-healing and less on individual healing than communal and “systems” healing. Even when working at the individual level, the shaman perceives the physical ailment of the individual body as a reflection of the “inherently sociopolitical and cosmological condition” (Greene 1998:641). One of the essential roles of the shaman highlighted by Mircea Eliade is “the defense of the psychic integrity of the community” (1964:509). Anthropologist Gerardo Reichel-Dolmatoff, who conducted much of his fieldwork in Columbia, describes the shamanistic framework for illness:

In shamanistic practice[,] illness is taken to be the consequence of a person’s upsetting a certain aspect of the ecological balance. Over-hunting is a common cause and so are harvesting activities in which some relatively scarce natural resource has been wasted. The delicate balance existing within the natural environment, between nature and society, and within society itself, is bound to affect the whole . . . the shaman is interested in the patient’s illness not so much as a function of biology, but rather as a symptom of a disorder in the energy flow.

I want to emphasize that the shaman as healer of illness does not so much interfere on the individual level, but operates on the level of those supra-individual structures that have been disturbed by the person . . . a Tukano shaman does not have individual patients; his task is to cure a social malfunctioning. The diseased organism of the patient is secondary in importance . . . (1976:9).

In the last fifty years, the growing interest in shamanism in the United States has clearly resulted from individualistic goals of personal healing and self-actualization, “a spiritual path of personal empowerment” available to anyone who chooses to follow it (Wallis 1999:42). The attraction of entheogens in the 1960s and 1970s, such as the
experimentation with ayahuasca, spurred on the movement of self-discovery and expansion of “reality.” In my interviews, the majority of medical practitioners stated that they began exploring and studying shamanic healing for personal use, a practice that they integrated into their professional practice only after discovering its personal benefits. In most instances, their interest in learning the technique of shamanic journeying was to address personal ailments—physical and more often, emotional. Most shamanic trainings offered to the public in the United States center on teaching individuals the technique of shamanic journeying for personal use. More advanced trainings move into techniques for healing other people, and from there, other living beings, or land and buildings.

Even as medical practitioners adopt shamanic healing into their medical practice, it is often used as a corollary for the primary objective – to heal an individual patient. Because “modern Western shamanism” is “oriented toward personal and spiritual empowerment among practitioners . . . the role of the community is of less importance than it is in shamanism’s more traditional context” (von Stuckard 2002:775). Thus while Gerardo Reichel-Dolmatoff explicitly describes the healing of an individual to be secondary to the traditional (Takano Indian) shaman’s motive – with primary emphasis focused on the reestablishment of order and balance in the natural world – the contemporary practice of shamanic healing in the United States has been initiated to address individual concerns, either for oneself or another person, and only secondarily is it being employed to address greater concerns of societal and ecological balance. As Sandra Ingerman, a well-known shamanic practitioner, trainer, and author, frames it:

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40 *Breaking Open the Head: A Psychedelic Journey into the Heart of Contemporary Shamanism* 2002 by Daniel Pinchbeck provides a cultural history as well as personal account of contemporary exploration of shamanism and psychoactive drugs.
“It’s not what you do, but who you become, that changes the world” (presentation at the Medicine in Shamanism conference, Sante Fe, NM, May 2004). In other words, in Western culture, we tend to view personal healing as a valued effort onto itself, or the means by which to heal the greater good. This may not always hold true (though even for those who now direct shamanic healing for concerns beyond the individual, initial interest often began at the personal level); and is not meant as a criticism of Western interest in shamanism, but as a point of comparison in its cultural emergence.

Privacy

Furthermore, privacy is a highly valued (and legally protected) right in the United States. Thus, in cultural compliance, the practice of shamanic healing in the United States often takes place in a private, one-on-one setting, rather than in a public arena. Sometimes shamanic-related conferences and gatherings include the facilitation of a group ritual for purposes of healing a member of the group (who often will sit in the middle of others forming a circle around them) or healing property in close proximity, or focused healing on a distant person(s), other living beings, place, or circumstance (e.g. world peace), but the group activity still tends to be a private affair. Shamanic gatherings are not held as open, public events on publicly-owned property. Many shamanic healers may use their home as the location for their healing work, often working out of a separate room designated for their practice. A small number of the medical practitioners that were interviewed for this study had a designated room in their home to conduct healings. And one practitioner hosted monthly drumming circles at her home for group healings.

In traditional shamanic cultures, group healing is more common, and understandably so given that the focus may be more communal and cosmological, with
individual healing being secondary. Or shamans may go to the home of the person in need where the rest of the family resides and often participates in the healing ceremony. In Western culture, there is greater emphasis on individualism and privacy, and thus most healing venues provide private space for the healer (and sometimes attending medical assistants) and the patient, in some cases accommodating close relatives such as a parent of a child, or the adult-aged child of an elderly parent. In medical establishments such as clinics, doctors’ offices, and hospitals, where the officiating healer is a licensed medical practitioner, HIPAA rules apply to enforce patient confidentiality, thus creating potential legal barriers to group healings. However, many have discovered that the advantages of group healings include synergistic effects of healing, bonding through shared experiences, benefits from ritualistic activity, and personal validation/training of different healing approaches. An MD who holds monthly drumming circles, that include focused healing on an individual sitting in the middle of the circle, stated that “often when there’s healing going on, other people receive healing other than the person for whom the ceremony’s being done. You can be healing one person and someone else will say, ‘gee, my headache is gone’” (Carol Englander, MD). Thus the benefits of group healing may be realized by some, but the fact that shamanism still sits in the shadows of cultural acceptance in the United States, along with a cultural and legal emphasis on privacy, limits such opportunities.

Group ceremonies that involve shamanic healing are taking place in the United States, but tend to occur in separate locations where the group will not be disturbed by others – or where the group will not disturb others who may not be comfortable with the practice of shamanic healing taking place. Whether practiced in an institutional setting,
or in someone’s home, or at a retreat center, shamanic healing is conducted in a covert, or privately overt forum in the United States – with the exception of American Indian communities where shamanism has been historically practiced and honored as a part of many tribes’ traditions.

Training and Initiation

In traditional shamanic cultures, a shaman is often first decreed through illness, a natural event such as a lightening strike, or recognition by a teacher. This is followed by a long, arduous training period that lasts for years, often involving activities of isolation or a solo journey, food deprivation, sexual abstinence, and other difficult regimen. Even when a shaman comes from a lineage of shamans, specific signs are looked for to signify their fated role. Thus the shaman is conferred by his or her community. [see Mircea Eliade, *Shamanism: Archaic Techniques of Ecstasy* 1964, chapters I-IV for detailed descriptions of such events in numerous shamanic cultures.]

However, in the United States, many shamanic practitioners are self-appointed and gain their stature through self-selected trainings and workshops rather than through an initiatory event. In other words, rather than experiencing an initiatory event which then alerts family or community that a “shaman” is in their presence, and thus requires further training, many shamanic practitioners in the United States feel drawn to study shamanic healing and after a series of trainings, self-announce their mastery (though often discreetly). As Joan Townsend avidly points out, a significant cultural difference between traditional shamanism and Western shamanism is the aspect of “democratization of shamanism.” “While in most traditional societies few will be shamans, in [modern] shamanism, apparently all or many who wish to can become a ‘shaman’” (2004:5).
[Though as stated in earlier discussions, “shamanic practitioner” is the more common term appropriated in lieu of “shaman” in deference to recognized differences between traditional and Western practitioners.]

Mircea Eliade noted in his research that self-appointed shamans tended to be less powerful (1964:13)—which many may agree with. However, as Allie Knowlton stated to me in a private conversation, “in Western society, much of the initiation process plays out in the stress of daily life, such as losing a job or relationship, or suffering an illness or injury.” To say what form of initiation identifies and validates a shaman or shamanic practitioner is difficult, for it may be culturally relative. Each community may derive its own standards, just as each state and country develops its own legal standards for anointing medical practitioners (e.g. via educational requirements and examinations).

Training requirements also vary. In traditional shamanic cultures, there is often a tradition of training—often lasting years. In the United States, since there is no certification process or legal standing for shamanic practitioners—nor a cultural tradition—each person may decide on his or her own when he or she is ready to begin formally practicing (i.e. charging a fee for rendered services). Some may attend a small number of workshops, while others attend lengthy trainings, for instance FSS runs a three-year apprenticeship program—but it is solely up to the individual as to when he or she chooses to begin a formal practice of shamanic healing. Allie Knowlton and Evie Rysdyk are self-appointed shamanic practitioners and attended the FSS three-year program before opening up their practice. A number of the medical practitioners interviewed also attended FSS workshops, including the three-year apprenticeship.
While each traditional shamanic culture practices a culturally-contextualized form of shamanism, endemic to its cultural roots, in the United States, there is no uniform culturally-derived shamanic practice. Practices are a reflection of practitioners’ training, and this varies greatly relative to place, practice, teacher, and tradition. Many of those interviewed studied shamanism at FSS-sponsored workshops, or with FSS-trained practitioners. Thus the basis of their practice may be Core Shamanism which is an amalgamation of common shamanic techniques without inclusion of the cultural attributes of any one particular shamanic tradition (though as argued earlier, not without Western cultural influence).

However, within Western shamanism, many of the practitioners interviewed have accessed other informational sources as well. Some studied with shamans from a particular culture (visiting or now living in the United States) or with shamans living in their traditional homeland, and thus have created their own unique pan-shamanic blend. Many weave in other alternative healing techniques, such as Reiki, Healing Touch, herbalism, homeopathy, yoga, etc. Furthermore, some practitioners gain additional knowledge of practices through direct revelation from their spirit guides, thus creating yet an even more personally-designed practice. Allie Knowlton relayed to me that she learned from Michael Harner that “teachers will appear as needed in people’s [own personal] journeys.” Allie went on to say that she does not feel that she needs to “go off to Ecuador or some foreign place to study with an indigenous shaman, but that [she] will meet them in [her] journeys as needed.” She went on to describe a new teacher that she

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had just met in her journey who is a real person, but who she has never met in person: “a wizened old woman living somewhere in the jungle in another country – but the woman won’t tell me where because she doesn’t want reporters, tourists, etc. bothering her. The woman told me that she’ll soon ‘be gone’, but before she leaves this world, she wants to pass on her knowledge to me.”

While some readers may find the above account farfetched, this is an example of how shamans work to gain information from their spirit guides. To a shaman, conversing with spirit guides is a form of divination, and is not simply an engagement with their deeper psyche. Connecting with a real-life shaman through a spirit guide is no less real than talking to someone who lives in Ecuador via videoconferencing.\(^\text{42}\)

**Application of Shamanic Healing**

While Allie and Evie and other shamanic healers may tend to use shamanic healing for almost any ailment or condition, either to treat the physical problem or the underlying emotional cause and/or outcome of the injury or disease, medically-trained shamanic practitioners tend to apply their shamanic skills to areas of patient relations (e.g. practicing greater sensitivity and empathy, enhanced listening skills, and a more spiritual and less technocratic approach); diagnostic purposes; and psychopomp work (to assist patients in the dying process). Shamanic skills were mostly used to provide additional support to the patient, but were much less likely applied to obtain physical

\(^{42}\) Mircea Eliade emphasizes the comparative role of shamans to other religious persons. “Only [shamans] know how to ascent through the ‘central opening’; only they transform a cosmo-theological concept into a *concrete mystical experience*. In other words, what for the rest of the community remains a cosmological ideogram, for the shamans becomes a mystical itinerary. For the former, the ‘Center of the World’ is a site that permits them to send their prayers and offerings to the celestial gods, whereas for the latter it is the place for beginning a flight in the strictest sense of the word. Only for the latter is *real communication* among the three cosmic zones a possibility” (1964:265).
healing outcomes. Practitioners often discussed their understanding of the greater connection between emotional states and physical ailments, and the value of a shamanic approach to support this understanding, but stated in their interviews that they used an allopathic approach when it came to treating the biological condition. As one MD stated, “shamanism doesn’t cure a stroke, but it aids in the recovery of one” (Bert, MD). This is not to say that my interviewees expressly devalued a shamanic (i.e. holistic) approach to healing, and many interviewees talked about the overlay of influence that their shamanic training offered to their overall approach to healing and working with patients. Yet they still expressed a strong dependency on treating biological conditions with allopathic approaches.

Thus, for those who are trained in Western medicine and shamanic healing, allopathic medicine appears to be the preferred treatment for organic conditions, but with a common recognition of the relationship between emotional/spiritual “dis-ease” and physiological disease. Within the medical establishment as a whole, there are at least incidental accounts of non-shamanically-trained physicians willing to acknowledge shamanic healing as a treatment of last resort. One interviewee who is renowned for his shamanic work with cancer patients, stated to me that physicians often refer cancer patients to him whom they consider terminal (Nathan, psychologist). Other practitioners noted that sometimes other physicians would refer patients to them whose biomedical options had expired. As stated earlier, there are no conclusive studies on the efficacy of shamanic healing to date, so whether one chooses to seek allopathic or shamanic healing, is more a matter of faith (though the two are not mutually exclusive either).
Whether a shamanically-trained medical practitioner offers one method over the other appears to be a matter of many factors, not only faith, but also experience, legal and professional concerns, and the attitude of the patient. Some practitioners appear to regard shamanic healing as a beneficial corollary to allopathic healing, enhancing the healing process while emotionally and spiritually supporting the patient and practitioner, but not necessarily inducing the biological healing process itself. Though as mentioned earlier, two of the 27 medical practitioners interviewed stated their consideration of leaving the medical profession in order to practice shamanic healing full-time, realizing greater value in the healing process and results of shamanism than those of Western medicine.

The shamanically-trained Western medical practitioners interviewed for this study (albeit a self-selected, but nonetheless existing group) clearly value shamanic healing, but how they apply their shamanic skills and for what purposes may be partly dependent on their personal experience and knowledge-base, as well as their professional security – and may also be affected extensively by cultural influences within their professional membership and the broader society.

This point also leads into the comparison of the societal stance of the Western shamanic practitioner and the traditional shamanic healer. Many of the interviewed practitioners discussed the legal, professional, and financial limitations to practicing shamanic healing as openly as they would choose. Many of them felt alone in their profession because of their interest in shamanism. Like the traditional shaman who is often depicted living on the edge of his or her community, and is both feared and revered, the modern-day shamanic healer in the United States often lives on the edge of his or her professional community. While they may be revered for their “special” healing powers,
they are also held in contempt by the established medical community (e.g. medical boards, administrators, insurance companies, and professional societies were all mentioned by interviewees) as well as seemingly jealous non-medically-trained shamanic healers and skeptical patients. However, in the United States, unforgiving parties are more likely to revoke the practitioner’s medical license or file a legal suit, rather than take the life of the unsatisfactory shaman as sometimes transpired in traditional societies (though of course some practitioners might view the former as a death-knell sentence of their professional self).

Although Western shamanic practitioners face the difficulty of living in a culture where shamanism is not embedded in the societal fabric of everyday life, they are able to find camaraderie through organizations such FSS and SSP, both of which include a significant number of members who are Western-trained medical practitioners. Both organizations publish journals on topics of shamanic healing, online informational websites, and membership listings, as well as sponsoring workshops, conferences, and gatherings. Some practitioners interviewed emphasized their aloneness while others regaled in their ability to serve as vanguards in a movement that is redefining health care. Those willing to reach out to shamanic societies appeared to be more comfortable in their role, while those who by nature tended to function alone, emphasized that aspect of their experience. Thus while most of those interviewed confronted cultural and institutional limitations in the practice of their shamanic skills, how alone they felt in their work appears to be partially a product of their personality.
Patients / Clients

Practitioners also expressed caution with and limitations from patients/clients. While a shaman in a traditional society also has to be concerned of his or her performance and outcomes with those on which he or she performs a healing, because the practice is so much less engrained in Western culture, patient reservation has a greater impact on shamanic practitioners in the United States. In both models of practice, almost every medical practitioner interviewed noted a conscious sensitivity to the language and/or terminology that they used to propose shamanic healing work. Practitioners often mentioned that they assessed their patients’ likely receptivity to shamanic work, such as their awareness of their patients’ religious and/or spiritual background. In many different reported accounts, patients who practice a fundamentalist Christian religion were found to be especially wary of shamanic work, equating it with the work of the devil. Whereas patients who expressed a more spiritual, and less-organized religious worldview, were the most likely to be overtly encouraged to consider shamanic healing.

Another limitation that a small number of interviewees mentioned is patients’ requests/expectations for a “quick fix,” rather than a desire to participate in or take responsibility for their healing process. The cultural metaphor of the United States being a “fast food nation” carries over into many aspects of people’s lives. The need for immediate gratification, greater efficiency, speedier devices is an aspect of a cultural sense of linear and limited time. Some practitioners discussed their efforts at trying to encourage patients/clients to take a more active role in their healing process in an attempt to form a partnership, rather than a hierarchical dyad.
In the case of one practitioner who worked with immigrant populations, patient limitations came from cultural expectations of a shamanic healer’s identity. The medical practitioner was female, but working with patients whose cultural tradition dictated that only males could be shamans. Thus when Western practitioners are working with immigrant populations in the United States, although the patients may be open to the practice of shamanism, they have their own pre-conceived dictates of the practice.

Another comparison of shamanic practice in the United States versus traditional shamanic cultures with respect to clients regards practitioner attire and adornments. The majority of Western practitioners claimed that their dress and office space remained conventional and did not provide any visual cues indicating shamanic work, though there were clearly some exceptions described. Claude Levi-Strauss (1963a) portrayed shamanic activity as a form of performance, theorizing that it was the shamans’ signature paraphernalia and antics that created an environment of validity for both the audience and practitioner. Mircea Eliade referenced the “elaborate ‘staging’ that obviously exercises a beneficial influence” on the patient (1964:511).

Yet Western shamanic practitioners often operate covertly or without outward adornments or theatrical antics, believing in the quiet connection to Spirit as the mechanism for achieving healing. Do Western practitioners actually have a greater belief and/or trust in the spirit world than traditional shamans? Or did Claude Levi-Strauss misplace the emphasis of traditional shamanic work based on his own misinterpretation of his observations? Afterall, even in Western medicine, surgical work is described as “performing an operation.” Although the patient is asleep when the operation takes place, he or she is exposed to some of the preparation that includes transport on a gurney,
operating room scrubs and masks, as well as visible post-operative markings such as
stitches, drainage tubes, etc. And both the surgeon and the patient presumably hold faith
in the healing powers of such medical treatment.

But for those who provide or receive shamanic healing in the United States, the
theatrics and props are much less significant than those described in traditional cultures,
i.e. much of the shamanic work provided by medical practitioners is void of
“performance,” and yet there still is a growing cadre of individuals who believe in its
healing powers. For many individuals, the lure of shamanism may be due to a counter-
cultural draw, an anti-materialist philosophy, a desire to be alternative, provocative . . .
But for the medical practitioners interviewed, it was a personal healing experience with
shamanic techniques that encouraged them to adopt some of its practices into their
professional healing work – even though it remains at a covert, nondemonstrative, level
for most. Thus the value of shamanic healing may be internalized because of culturally-
pressive attitudes, and the outward identifiers of it, such as costumes and props, appear
not to be necessary to those attempting to tap into its healing powers.

Legal Institutions

In the United States, people’s actions are dictated by legal institutions as well as
societal norms. Thus for many shamanic practitioners, the limitations are encountered on
both fronts. One medical practitioner interviewed works in the state of Utah and
explained that his ability to practice more overtly than many other practitioners is due to
greater leniency in alternative healing. He reasoned that because Utah has a high
population of Mormons\textsuperscript{43}—of which hands-on-healing is a prescription of its religious practice—comparable healing approaches, such as shamanism, are more acceptable, even within the confines of public medical institutions, such as hospitals. In recent years there has been a movement to pass state and federal legislation regarding medical freedom. A number of states have recently passed Medical Freedom Bills that protect patient access to alternative therapies from licensed physicians, i.e. thus also protecting physicians from malpractice suits for advocating alternative therapies. These states include: Alaska, Colorado, Georgia, Massachusetts, New York, North Carolina, Ohio, Oklahoma, Oregon, Texas, and Washington (\url{http://www.cancure.org/legislation_already_passed.htm}). Ultimately, for most medical practitioners, there is always the fear of a malpractice suit lurking. [see Cohen and Eisenberg. 2002. “Potential Physician Malpractice Liability Associated with Complementary and Integrative Medical Therapies.” In: \textit{Annals of Internal Medicine}. 136:596–603.]

\textbf{Commodification}

As has been stated, a key cultural difference between the practice of shamanic healing in the United States compared to a traditional indigenous subsistence society relates to economic precepts. In the United States, almost every aspect of existence has been commodified, be it a good, service, or intellectual commodity such as a patent, trademark, or even an original idea. Shamanism practiced in the West is no exception. Whether one is practicing shamanism, studying shamanism, or experiencing it in another culture, money usually passes hands. There are innumerable workshop offerings on

\textsuperscript{43} The Pew Forum on Religion and Public Life: “U.S. Religious Landscape Survey” 2007 reports that the U.S. population of individuals of the Mormon tradition is just over 2%, but in the State of Utah, it is measured at 58% (\url{http://religions.pewforum.org}).
shamanism, from a short evening class to learn how to journey, to multi-day workshops offered at most retreat centers, to two and three year apprenticeship programs that typically meet a few weeks or a small number of weekends per year at a designated site. Often participants travel extensively to attend these sessions, even flying across the country. Thus the cost of training for an individual can easily run into the many thousands if one so chooses to take advantage of organized trainings.

Many organizations also offer expeditions, typically running one to three weeks, to visit a traditional shamanic community where participants have the opportunity to observe and experience an indigenous shaman’s work. These trips often cost in the range of two to four or five thousand dollars plus airfare. This commodification of shamanism has the greatest impact on traditional shamanic communities. The benefits and detriments are somewhat comparable to those raised in the debate of ecotourism’s impact on the local community. Trips to traditional shamanic cultures provide financial support to the community shaman (as well as other community members) and provide validation of shamanism to members of the community who may feel that the ancient practice is outdated and of no interest to the global/Western world. This may pique interest in younger members of the community to study with an elder shaman, which is of importance given that many elder shamans have no one to pass their craft onto before they die. However, such trips also transport Western influence to indigenous communities that may not have much access to the outside world; as well as U.S. dollars that may breed contempt between competing community members or create other negative consequences.
Organizations have sponsored programs to provide financial support to indigenous shamans, such as FSS’ “Urgent Indigenous Assistance” project and “Living Treasures of Shamanism” program. Mark Plotkin’s organization runs the “Shaman Apprenticeship” program to support the study of shamanism by members of traditional communities working with their tribal shaman elders. The admirable intent is to sustain the practice of shamanism in its traditional form, but it also inflicts a degree of Western dominance, serving as the “arbiter and authority over who is and who is not a ‘true shaman’” (Johnson 1995:172).

Within the United States there is much debate about the charging of fees for shamanic services, some of which was discussed in chapters 4, 5, and 6. Because of the high cost of shamanic training, a shamanic practitioner charges a fee usually somewhere in the range of $150 for a two-hour session. Some charge for a session regardless of the time involved, though two hours is an average time allotment. Others may charge by the hour, in the range of $50 to $100 per hour. It appears that the fees are comparable to what many psychotherapists charge for a session.

Sandra Ingerman, one of the most renown Western shamanic practitioners states that “there is nothing wrong with charging money” for a shamanic healing session given that in all shamanic cultures “there have been different forms of exchange for shamanic work. Some shamans charge money. And in some cultures, a client might have to supply food for the shaman for his or her family for a month.” Dollars happens to be the “method of exchange” in the United States. However, Ingerman also emphasizes the imperative that people should practice their skills for free and not charge a client fee until
they have determined “they are getting good results” (SSP online newsletter, June/July 2008).

With respect to cost, on the one hand, given that shamanic healing is not covered under health insurance, even one shamanic healing session can be beyond the affordability of many individuals, let alone a series of sessions that may be needed to deal with more problematic conditions. This of course raises a number of issues regarding the equity of access to shamanic healing. On the other hand, the cost of even a series of shamanic sessions is miniscule compared to the cost of most Western health care practices, from physician visits, to laboratory tests, surgery, and high-tech treatments, most of which are becoming more costly, including the out-of-pocket expenses covered by the patient.

Sandra Ingerman recommends that practitioners adopt a flexible fee and adds that she “never turn[s] anyone away from performing a shamanic healing who cannot pay for it. . . . Performing shamanic healing work is a service. And we all have to explore deeply what being in service to the spirits and the planet means and how at the same time we can balance out taking care of our own financial needs” (SSP online newsletter, June/July 2008). Thus financial access to shamanic healing work often depends on both the client’s interest and commitment as well as the practitioner’s guiding objective. As Ingerman pointed out, shamanic work is not just a professional practice for income generation, but a service to all those in need.

Although shamanic healing as yet is not covered under health insurance plans, as has been discussed in earlier chapters, many shamanic practitioners argue that the insurance industry would cause practitioners to become technicians rather than healers
(also a philosophy expressed by most TN practitioners) and would dictate a certification process for shamanic practitioners that is placed in the human realm, rather than the spirit realm. Most of the medical practitioners interviewed stated that they did not charge for shamanic healing services unless it could be included under a medical procedure that qualifies under the patient’s health insurance – or they performed a separate shamanic healing.

**Distribution of Power**

CMA roots its study of health-related issues within the context of class and power relations. While in traditional societies a member might more readily access healing through a shaman (if available) than Western medicine because of the higher cost of biomedical treatment, in the United States, as stated above, a shamanic healing might be cost-prohibitive to some members of society because it is not covered under insurance. The credo that shamanism is “a service to those in need” may help minimize limited access to shamanic healing, but this depends on the professional philosophy of the individual healer. The fact that some medical practitioners will incorporate shamanic healing into their medical treatment at no additional charge is another means by which to reduce financial limitations on access to care.

In the case of True North, the health center has had to prove wrong its reputation of being “a health care boutique for the wealthy.” TN members have chosen not to accept health insurance for the very reason that it bureaucratizes health care and limits time allocation with patients as well as preventative approaches to better health; and yet the capitalistic system of insurance has created more of a bind for TN practitioners than any other one issue. True North provides services to low-income patients through the
Maine Time Dollars program and through grants. As well, over time, more and more people may discover a high dollar value in the health care regimen received at True North. As one practitioner noted, it also is a matter of patient priorities. “People don’t feel they have to make an active decision to heal. People might spend money on a new suit, but not on a shamanic healing” (Neal, DO). A capitalist orientation in society has promoted a culture of choosing consumer goods over the care of our bodies – how we look on the outside is often valued more than how we feel on the inside.

CMA not only provides analysis at the macro-social level wherein it examines health-related concerns on a global economic scale, but also at an intermediate and micro-social level. The intermediate social level addresses relationships between and among administrators and health workers. raising concerns of a ”medical hierarchy [that] replicates the class, racial/ethnic, and gender hierarchy” manifest throughout society (Baer et al. 2003:42). A number of interviewees referenced acknowledgement of such hierarchies with respect to their practice of shamanic healing. Practitioners noted concerns about administrator responses who secure the financing of health care institutions and their employment; or nurses and physician assistants wary of medical doctor responses to their practice of shamanism. A DO talked about medical doctors viewing his field “below” that of MDs. During an interview, one MD reflected this attitude of high status in his comment that the “American public still looks to physicians as the top of the health care pyramid. So I think [the validation of shamanic healing] needs to come from within a medical framework” (Stan, DO).

And yet there were also MDs who commented on their experience of reverse prejudice from non-medically-trained shamanic healers due to their biomedical training.
Thus a non-conventional healing modality cannot circumvent the repercussions of a hierarchical system once adopted by members within such a society, and adds further challenges to those in positions of lesser power who choose to practice it.

CMA’s microlevel of analysis primarily refers to physician–patient relations. It is countered that the physician role “performs two key functions for the encompassing social system and its existing distribution of power: (1) controlling access to the special prerogatives of the sick role and (2) medicalizing social distress” (Baer et al. 2003:43).

In the case of practitioners who have studied shamanic healing, in many of the interviews there was an expression of attempting to treat the patient as an individual rather than a pathology, to be a better listener, and to afford greater awareness to the relationship between physical ailments to that of emotional concerns and life stresses. With respect to True North, practitioners referenced a goal to practice patient–centered healing.

Ultimately, in one manner of speaking or another, many of my interviewees expressed the desire to empower patients and create a healing dyad between practitioner and patient, rather than replicate the conventional hierarchy. But as mentioned above, this requires that the patient take a more active role. As one physician assistant noted, often patients “just want the pill, they just want the surgery” (Ellen, PA)—a reflection of a broader “quick fix” cultural mentality. Thus the role of capitalism and political–economic forces that play upon various social processes, including health care, is reflected in, as well as affecting the way in which shamanic healing is adopted into a biomedical system for both the provider as well as the recipient.
Concepts of the Body

“Anthropology of the body” is a field of study whereby social scientists explore how different societies and cultures conceptualize and experience the human body. A large and varied body of literature offers examination of the socio-cultural and political-economic dynamics that shape the (self-) perceptions and understandings of the body and in turn how the body displays the effects of social process. This also pertains to how people in different cultures perceive and experience disease and disability, health and healing, as well as death and dying.

Within the framework of the social construction of the body, there are conceptual differences between Western “scientificized” societies and traditional cultures. The former perceives a more corporeal, mechanistic view of the body, with capitalistic value, while the latter embodies a more nature-based and spiritually-based perspective. The body perspective in traditional cultures is less boundaried and there is a greater sense of reflection of the landscape within the body, and vice versa as noted in an iconic Native American adage: “The earth is our mother.”

Within the field of medicine, there is a history of changing perspectives on the function and attributes of the body, as well as present-day differences between different medical systems. Even prior to the Cartesian body–mind split from which a highly


45 For an overview of differing perspectives on the body within different medical systems, see Claire Monod Cassidy’s chapter, “Social and Cultural Context of
reductionist approach to medicine took hold, oppositional schools of thought existed: the vitalists and the mechanists. Vitalists believed illness was the result of psychic or spiritual forces whereas mechanists believed it to be biologically-based (Watkins 2001:202). In the 1700s, to counter Cartesianism, the idea of anima or “sensitive soul” was proposed as “the agency that made life distinct from lifeless matter” (Kaptchuk 2001:44). A modern-day perspective on a human being recognizes four relational “bodies” such as physical, mental, emotional, and spiritual; or physical, psychosocial, energetic, and spiritual (Cassidy 2001:29). Yet central to the modern practice of biomedical science is a reduction of the body to cells, genes, and molecules (Micozzi 2001:xiii), confining attention solely to the physical body. Whereas the practice of shamanic healing gives the greatest address to the spiritual body.

An interesting comparison of perspectives on the body was discussed by plastic surgeon, Dr. Eve Bruce. She continues to run a private practice in the United States, but also has studied shamanic healing both at home and abroad, and incorporated certain shamanic precepts into her plastic surgery practice. In an interview with Dr. Bruce, she stated that as a young adult, she felt people in the United States were obsessed with their bodies and needed to focus less on their physical being and more on their spiritual being. But after traveling to indigenous cultures where she found people “lived and breathed spirit, where they really do embody spirit,” she realized that [Americans] “don’t need to get out of their bodies, they need to get into their bodies. We’re all in our heads. Our heads are highly developed. I don’t think that’s a bad thing. It’s just imbalanced.” Thus one of Dr. Bruce’s efforts as a plastic surgeon is to support people in developing a better

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relationship with their own bodies, and helping them feel more comfortable “inside their own skin.” Ultimately, bodily function and make-up, body image and relationship, health and healing – are all circumscribed by cultural definition rather than scientific absolutes.

**Healing the Community**

Though most of those interviewed focused their use of shamanic healing toward individuals, there are leaders in the Western shamanic community who are attempting to work on a broader level of societal healing. I will present three examples of special import (though others may be doing similar profound work as well). One example is psychotherapist and shamanic practitioner Ed Tick who founded the organization, Soldier’s Heart, in Troy, New York. “Soldier’s Heart is a veterans’ return and healing project designed to address the emotional and spiritual needs of veterans, their families, and communities” affected by the ravages of war (http://www.soldiersheart.net).

Another example is John Perkins, author and founder of the organization Dream Change. John has recently directed his attention to corporate activity, believing that for the first time, a world empire exists. In a personal interview he explained that following World War II, a corporatocracy was formed that is not governed by an emperor or king, but rather by a small group of “top” people who “just keep moving back and forth between government and corporations.” He went on to explain that “these corporations have created networks that reach across the planet and could solve most of our problems, such as the 24,000 people who die of starvation every day. But they aren’t doing that. So I think one of the keys of transformation of our culture today lies in shapeshifting the corporation.” Perkins dedicates much of his time working with corporations to support a shamanic perspective, in which he trains corporate employees and leaders to “journey to
other worlds and see a new vision.” “If life on this planet the way we know it today is going to continue, then we have to change this world that we’ve created, and probably we won’t be able to do that unless we change the corporations because they’re running the world.”

Another shamanic practitioner and well-known shamanic trainer who I interviewed mentioned his psychopomp work with clients. Myron Eshowsky cited clients who told him of their ability to find a sense of peace as they faced a terminal illness, adding that “people finding peace before they die is as important as people being cured.” But Eshowsky does not stop at supporting “peacemaking” with individual clients. Director of Pathways Foundation for Peace and Healing, he has embarked on community-based peacemaking through his work in prisons, community mental health centers, and with gangs and youths-at-risk; as well as international peacework.

Eshowsky feels this is where he needs to direct most of his energies at this point, rather than working at the individual level, and has served on United Nations’ delegations to implement shamanic work in specific cases of national conflict, such as those taking place in Central Europe and the Middle East. Eshowsky stated that officials realize that “traditional dialogue isn’t working and they’re trying to bring in fresh ideas.” [For further description of his work, see “From Revenge to a Healing Peace” in Shamanism by Myron Eshowsky, 2004.] Thus while many Westerners are still working at the individual level of healing – which is without argument, an important task – there are a few exemplary examples of individuals adapting shamanic work to heal at a communal level, not only locally, but globally.
Connection to the Environment

One of the underlying goals of this research was to determine the attraction to shamanic healing. As stated at the beginning of this chapter, Gerardo Reichel-Dolmatoff described traditional shamanism as a mechanism for attending to the human–natural environment relationship, such as weather control and hunting to increase food production. Anthropologist Peter Furst states that shamanism is “an ecological belief system” and that it “expresses a philosophy of life that holds all beings – human, animal, or plant – to be qualitatively equivalent: all phenomena of nature, including human beings, plants, animals, rocks, rain, thunder, lightening, stars and planets, and even tools, are animate, imbued with a life essence or soul” (1994:2–3).

Yet in my interview process, I discovered that although some practitioners were drawn to shamanism to strengthen their connection to the natural world, or that the practice awakened their connection to the natural world, the majority did not include this as a primary reason for their interest. Furthermore, practitioners that offer shamanic workshops focused on healing the earth stated that they had far fewer attendees interested in this topic. They found that the emphasis needed to be placed on personal healing—physical, emotional, and spiritual—and expressed the hope that through such healing, individuals then might become more aware of their connection to the earth. Sandra Ingerman, author of Medicine for the Earth 2000 reported that when she put the words “environment” or “nature” in her training titles, it was more difficult to fill her workshops; and Allie Knowlton and Evie Rysdyk stated similar experiences. Even FSS had to drop its “Shamanism for Healing the Earth” project for lack of interest (M. Harner 2005a:6). Ingerman added that she draws larger crowds for her signature “Medicine for
the Earth” trainings in Europe than in the United States, commenting that “Europeans understand the problem of polluting water and how it comes back to them. Americans are more self-absorbed.” Ingerman also noted to me in her interview that Michael Harner’s trainings in Core Shamanism leave out a shamanistic emphasis on human–environment relationships. Ingerman believes that one’s relationship to nature as well as spending time in nature is “the way to bring back the soul of shamanism” – and that this is her “calling.”

Thus rather than an individual’s connection to the natural world being a primary concern, with personal healing being secondary, as is practiced in many indigenous cultures— in the United States, the healing process moves from the personal to the world around them. In most cases, only after an individual has dealt with his or her internal make-up, does one extend his or her ability to connect with the ambient environment and focus on healing the earth. This may be due to the fact that Westerners are less dependent on their immediate environment for their food supply, and rarely live a subsistence, nature-based lifestyle. But it also must be recognized that Westerners operate under a deeply engrained cultural paradigm that includes the separation, hierarchy, and commodification of nature.

An interest in ecological stewardship is not void within the discussion of Western shamanism, and it has been argued that a formative phase of neo-shamanism began within nineteenth century Western movements such as romantic metaphysics and transcendentalism (von Stuckard 2002). Yet deeply engrained attitudes toward nature are strongly divergent between most members of Western versus non-Western cultures.
Mircea Eliade describes a center post of the shaman’s practice which he refers to as the “World Tree” or “Cosmic Tree”:

The Cosmic Tree is essential to the shaman. From its wood he makes his drum; climbing the ritual birch, he effectually reaches the summit of the Cosmic Tree; in front of his yurt and inside it are replicas of the Tree, and he depicts it on his drum. Cosmologically, the World Tree rises as the center of the earth, the place of earth’s ‘umbilicus,’ . . . The Tree connects the three cosmic regions. Its branches touch the sky and its roots go down to the underworld (1964:270).

Anthropologist Jeremy Narby asked the question of how a group of Amazonian people with no knowledge of chemistry or physiology, and without electron microscopes, could discover the concoction of ayahuasca—produced from combining “leaves of a bush containing a hallucinogenic brain hormone” and “a vine containing substances that inactivate an enzyme of the digestive tract, which would otherwise block the hallucinogenic effect”—among 80,000 Amazonian plant species (1998:11). While conducting fieldwork with the Ashaninca in the community of Quirishari in the Peruvian Amazon’s Pichis Valley, Narby explored this question, learning about “plant-teachers” and plant spirits. His informant told him that ayahuasca was the mother of plants, and tobacco its child; and that one can hear them like the way one can hear radio waves (1998:30–31). What he concluded, albeit in very simplistic terms, is that the shamans could communicate with the plants via all of life’s common building block—DNA. While clearly surpassing Western scientific constricts of nature’s inanimate essence, Narby still attempts to understand the shaman’s plant skills within a framework of molecular biology. Ethnobotanist Mark Plotkin has asked the same question about plant identification and provided some theories including taste tests (e.g. a bitter taste signifies the presence of alkaloids, the single most important chemical component of modern medicine); visual color that informs internal chemistry; and the doctrine of signatures
(appearance may mimic curing potential)—but also adds another source: “a shaman’s dreams” (2000:196–197).

In my interview with pharmacist Connie Grauds, I asked about her thoughts on the comparison between Western-trained pharmacists’ perspectives on plants versus traditional shamans’ views. She explained that U.S.-trained pharmacists view plants as “‘weak drugs’ and attempt to identify the active ingredient and mechanism of action in the physical sense. Whereas the shaman would say that the plants have ‘spirit doctors’ in them, and that they have spiritual qualities. Just as humans have bodies and spirits, so do plants.” The movement of Western shamanism includes the study and use of plants, and journeying to the plant spirits. Although this specific aspect of Western shamanism requires further investigation, few of the interviewees in this study even mentioned “plant spirits” though they often are central to a traditional shaman’s work. However, it should be noted that Larry Dossey, MD and former executive editor of the magazine, “Alternative Therapies” published an article on green medicine, discussing not only the value of herbal medicine in CAM, but also ideas on “listening to plants” and “human-to-plant communication” (May/June 2001). So there is some recognition of plant spirits within Western alternative medicine, but it does not receive the degree of emphasis entertained by traditional shamans.

Thus it needs to be recognized that the practice of shamanism in the United States is still performed by many within the cultural framework of Western science. Many Western shamanic practitioners may never be able to fully reach body–soul/human–earth–spirit connections that are basic tenets of traditional shamanism, but will include shamanic healing techniques as an addition to their biomedical approach to healing. For
some, the tenets of shamanism have awakened an ecological awareness and greater desire to ‘connect’ with nature. But for many, it still may be difficult to break free from the cultural confines of the Western scientific paradigm and perceive nature in a manner similar to traditional shamans. Gerardo Reichel-Dolmotoff clarifies the difference between the act of connecting or “harmonizing” with nature (a goal often cited by ecologically-minded Westerners) and an indigenous mindset regarding nature.

The cosmological myths which express the Tukano world-view do not describe Man’s Place in Nature in terms of dominion, or mastery over a subordinate environment, nor do they in any way express the notion of what some of us might call a sense of ‘harmony with nature’. Nature in their view, is not a physical entity apart from man and therefore, he cannot confront it or oppose it or harmonise \[sic\] with it as a separate entity (1976:11).

And yet, with the many individuals in the West who are studying and adopting basic principles of shamanism, such as the belief in the existence of a spirit world, they are also pushing on the cultural edges of the Western scientific paradigm and the biomedical model of health care now prevalent in the United States. Ultimately, this may induce some major shifts in the way health care is practiced in the United States to date. But this shift will need to occur in tandem with an overall cultural conversion in mainstream Western attitudes toward nature. Healing activities at the individual level will not be enough to maintain a healthy populace. Even a healthy lifestyle and personal access to adequate health care will not deter deleterious effects from a contaminated and depleted environment. Attention to humans’ treatment of the environment and healing at a community level is needed.

Critical medical anthropologists refer to a “political ecology of health” in which central importance is given to human agency to address the impact of economics on the human health–environment relationship (Baer et al. 2003:74). As those who work toward
a deeper connection with themselves, their neighbors, and the world around them, via shamanic tenets or other consciousness-changing practices, apply their influence in the way they work and live, a paradigmatic cultural shift could result. Fortunately, both shamanic healing models examined in this study offer a contribution toward this vision.
CHAPTER 8

THE APPROPRIATION OF INDIGENOUS KNOWLEDGE: REFLECTIONS ON WESTERN SHAMANISM

Introduction

In the 1960s, a team of physical anthropologists was conducting research on hypoxia and lung development among a group of Andeans living on the altiplano of Peru. It was discovered that individuals raised in this high altitude environment (which has a lower atmospheric oxygen content) developed greater lung capacity. Data collection involved participants volunteering to expire rapidly into an apparatus (a shiny metal container) that measured air volume. It was recounted that one of the Quechua expressed concern that the anthropologists were collecting their air in oxygen cylinders (present in the laboratory) and shipping it to the United States to fortify the performance of American Olympic athletes. Appropriation of vital essences (e.g. body fat, blood), especially by outsiders, is a common fear among the Quechua.46

This story is a powerful metaphor for many of the points that I will make in this chapter. But first I will summarize the research findings of the above study. The data showed that greater lung capacity developed during Quechua childhood and that this was predominantly a plasticity response to their environment, i.e. lower oxygen availability, rather than a genetic adaptation passed along from biological parent to child (regardless of environmental conditions). This differentiation in modes of human adaptation will come into play later in the discussion.

46 Other examples include: (1) the belief on the altiplano that a tall white person—a pistaco—will engage a native in conversation while walking alone in the country. As he talks he sucks the native's fat which is a valued bodily substance (most high altitude animals have low body fat levels); (2) blood is also thought of as a vital essence among the Quechua, and there can be serious consequences if someone of ill intent takes some. Even the use of a blood pressure cuff caused concern among some volunteers. As blood flows under the cuff when pressure is released, a throbbing sensation occurs that some believed was due to the cuff sucking out their blood. This underlies a fairly pervasive feeling among campesinos on the altiplano that outsiders come to the community because they want to take something away (personal communication with R. Brooke Thomas).
Obviously this story might bring a smile to the reader; the humorous notion that one’s air could be “stolen” or confiscated. But it is not so farfetched a concern. Indigenous peoples have suffered untold colonialist exploitation at the hands of Westerners, even well-meaning ones, for over five centuries, resulting in environmental degradation, economic disruption, ethnocide, and genocide. In a globalized world, various aspects of that which is deemed “indigenous” are being extracted and inserted into the free market world economy. In the wake of activities initiated by the World Bank, the International Monetary Fund, and the World Trade Organization (e.g. GATS, NAFTA, CAFTA, TRIPs\(^47\)), the matter of privatization becomes a central theme, i.e. who has rights to “public commons” such as water, forest lands, genetic structures of plants and humans, and even codified “knowledge” (Mander 2005:5).

The health-craze in the West and scientific advances in the medical field have spurred attempts to commodify indigenous healing rites, as well as the use of medicinal plants (Tauli-Corpuz 2005a:13). Through the application of property law, namely patents, corporations claim proprietary rights and thus profit. Some have dubbed these actions “biopiracy,” “bioprospecting,” or “biocolonialism” because the potential costs to “indigenous peoples and the Third World poor are very high [given] two-thirds of the people in the South depend on free access to biodiversity for their livelihoods and needs” (Shiva 2005:71). Even tourism (the world’s largest service industry) and the more well-

\(^47\) Through the World Trade Organization, the United States instituted a global patent system based on intellectual property rights entitled, the Trade Related Aspects of Intellectual Property Rights Agreement (TRIPs), signed in 1994. Under this agreement, corporations can make minor genetic modifications in seeds and living organisms and become a patent-holder with monopolistic rights. Monsanto owns intellectual property rights to eighty percent of all genetically engineered seeds planted. Patents now exist for neem, haldi, pepper, harar, bahera, amla, mustard, basmati, ginger, castor, jaramla, amaltas, new karela, and jamun (Shiva 2005:69–71).
intentioned ecotourism have honed in on indigenous resources and rights. “Among the most degrading effects of ecotourism is the marketing of indigenous heritage, cultural identity, and sacred rituals” (York 2005:115).

When looking back at the Quechua’s fear of their very breath being confiscated, they may have sensed the coming of a new era of proprietorship, when corporations now can patent everything from a genetically-altered plant, the DNA sequence of an individual, a formula, or an idea. The archaic definition of “inspiration” is “to breathe or blow life into or upon.” Through breath we connect with spirit and receive insight or inspiration. And thus the question of appropriation of one’s inspiration, or wisdom, or knowledge, needs to be examined. Debra Harry of the Indigenous People’s Council on Biocolonialism and a Northern Paiute states in a recent report on indigenous rights:

Nearly everything that we hold collectively, and value as peoples is at risk of appropriation and subject to the new global market in genetic resources, including Indigenous foods, medicines, and even our traditional knowledge [emphasis added] developed by, and passed down from generation to generation over millennia (Harry 2005:60).

It is certainly understandable that any indigenous group would be wary today of foreigners seeking out their land, their culture, their very bodies. Thus even when it comes to the practice of shamanism by Westerners, i.e. neo-shamanism, it is important to evaluate what is appropriate action in the adoption of this ancient magico–religious tradition.

Response to my research investigating the integration of shamanic healing into the biomedical model practiced in the United States has aroused a number of comments. Some individuals (both indigenous and Western) have expressed the notion that people of European descent should look to their own traditional past (e.g. Celtic heritage known to
have shamanic lineages), rather than emulate unrelated indigenous practices. Often I received the more vehement response that a person cannot simply call themselves a “shaman” or practice shamanism without direct ancestral heritage or divine appointment (e.g. being struck by lightning) – if a white person can ever become a shaman at all. Some have argued that shamanic rituals are steeped in locality, both environmentally and spiritually, and cannot simply be replicated elsewhere with effect – or without insult to the spirits. Among indigenous peoples, there are also those who advocate the position of “cultural ownership” of certain practices and rituals, while others argue that sharing their practices with “the white man” may be the planet’s only hope of survival at this point. I also have encountered individuals who had not given the issue of appropriation any thought. But clearly it is an issue of critical consideration—and one that provokes many diverging opinions. The question ultimately distills down to ‘Who has the right to call themselves a shaman and to practice shamanism?’ In the following pages, I present a very defined perspective on this issue, one that some readers may agree with, others not. But ultimately the intention is to foster awareness and discussion to those involved in the study and practice of shamanism, be they of indigenous or EuroAmerican descent.

Although “medical pluralism, or the existence and use of many different health care alternatives within societies, is the rule and not the exception the world over” (Stoner 1986:44), the majority of examples involve the blending of different indigenous practices or combining biomedical practices with traditional practices in an indigenous setting. Only more recently have traditional healing practices been integrated into institutionalized medicine in the United States. The long-held, unified belief that biomedicine is scientifically more advanced than indigenous healing, and thus more
effective, is crumbling. As referenced in chapter 1, a “reverse technology transfer” has been identified in which therapeutic approaches associated with ancient health traditions have been increasingly integrated into medical practices in the United States (Micozzi 2002:400). As more and more Westerners seek out shamanic training (some through travel to indigenous communities), and begin to practice shamanic healing in the United States, it is imperative to address if and how it can be carried out without further exploitation to the indigenous source communities.

I will now outline a set of arguments as to what constitutes appropriation of indigenous knowledge with respect to Western shamanism. Adoption of shamanic healing can be broken down into three key considerations: (1) indigenous knowledge/shamanic knowledge; (2) proprietorship/ownership; and (3) spiritual sensitivity/sacredness.

Indigenous Knowledge / Shamanic Knowledge

Indigenous knowledge often is defined in contrast to Western knowledge. Indigenous knowledge is considered prescientific, relative, and parochial. Western knowledge is considered scientific, technology-centered, and universal. Medical systems deemed “traditional” versus “modern” are denoted with the same contrasting characteristics (Stoner 1986:44). Indigenous knowledge comes from indigenous communities that practice economic subsistence, complex social systems, a nature-

48 The working definition used by the United Nations: “Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural
based ideology, and a animist spirituality steeped in what Western science might label ‘superstition’. But few indigenous communities still operate in isolation of the rest of the world, whether by choice, force, or necessity. As the world becomes more interconnected, the lines that delineate one culture from another become more and more blurred. This is not an advocation for homogeneity, but a matter of respect for the dynamic cultural shifts that occur in indigenous communities, just as they do in the West. Indigenous peoples are not static, frozen-in-time museum pieces.\textsuperscript{49} While we can talk in terms of general frameworks, we need to avoid the act of essentializing and be cognizant of how we associate characterized knowledge systems with particular groups of human beings.

As discussed in chapter 3, the definition of the term “shaman” varies, but I will use a fairly common, generalized notion as one who accesses altered states of reality and serves as an intermediary between the human and other-than-human world. In particular, the role of a healing shaman is to restore a systematic balance to the inner environment of his or her client with the outer environment that includes the human community and surrounding environs (Abram 1996; Bodeker 1999; Eliade 1964; Lewis-Williams 2003; Reichel-Dolmatoff 1976; Whitley and Keyser 2003). The growing phenomenon of its practice in the West is often disparagingly referred to as “New Age,” but its Western

cultural roots dig deep into past movements of Western mysticism and philosophy of nature as well as Eastern and indigenous traditions (von Stuckard 2002). Thus it can be argued that Western or neo-shamanism is not simply an importation of a traditional practice unrelated to EuroAmerica’s ancestral roots, but an evolutionary development in Westerners’ own struggle with their relationship to nature.

This argument can be extended back still further in time if we look at the evolutionary development of consciousness. Anthropologist Brian Hayden theorizes the development of religion, including shamanism, through the analytical lens of cultural ecology. He argues that human emotional responses developed due to environmental triggers, and that “all of our distinctive emotional reactions, including religion, evolved under hunting and gathering lifestyle conditions” (2003:24). Hayden goes on to point out that altered states of consciousness occur in the reptilian or oldest section of our brain and that our ancestors’ first religious experiences may have been caused by environmental stress, e.g. hunger, thirst, cold, sleep deprivation, and physical exhaustion. Extreme evolutionary changes in early hominoids that occurred about five million years ago coincide with severe climatic changes, namely a severe drought on the savanna in eastern Africa (2003: 20–45). An “irony of nature [is that] severe adversity seems to lead either to death and extinction or to a transcendence of the situation through transformation. This is as true in psychological, social, political, and shamanic terms as it is in genetic terms” (Hayden 2003:25). Hayden concludes that altered states of consciousness are not simply learned behaviors from particular cultural traditions, but are part of our human evolutionary development, ultimately stemming from ecological adaptations (2003:399–400).
If we can accept Hayden’s thesis, then we need to acknowledge that most individuals have at least some potential capacity for shamanic-like states of activity, and that this activity may likely be initiated by environmental stressors (as well as social stressors, illness, trauma, etc.). It possibly even may be a genetically selected-for trait (McClenon 1997). Although the standard of living for Westerners is much higher on average than those living in traditional communities, many would agree that the modern world imposes psychological stress (alienation, anomie, depression, anxiety, etc.) as much as it offers up the comforts of home. Our world has transformed incredibly over the last mere 300 years, and industrialization may be one of the most significant cultural ecological forces at play in modern times (Hayden 2003:413).

Thus to argue that shamanic experiences are only a product of indigenous peoples would purvey a rigid dichotomous view of what it means to be human; both anointing indigenous peoples as iconic (part of the “noble savage” syndrome) while denying Westerners a rightful place in their evolutionary development. Westerners may be “out of practice” so to speak due to a cultural hiatus, but their inherent capacity is no less. And while some Westerners may seek out indigenous or indigenous-trained shamanic teachers, many others are finding their source of power and practice through their own journey work. They have found a direct connection to the collective consciousness of their early ancestors. Thus their “inventiveness” that some may feel lacks authenticity may be no less authentic than our early hunting and gathering ancestors who began drumming around the fire pit in altered states. Acquiring shamanic knowledge through direct connection with the spirits, rather than through transference from a shamanic
teacher is a traditional practice in some indigenous societies as well, such as the Chuckchee of Siberia (Bogoras 1904:57).

Returning to the differentiation between genetic adaptation and developmental adaptability, shamanism may involve some genetic predisposition—given that many shamans come from a family lineage (though this does not discount the degree to which enculturation plays a factor). However, it may also be highly affected by our cultural ecology, i.e. our environment, and result more from human’s high degree of plasticity, i.e. developmental adaptability.

In contrast to a single set of cultural norms or values or rules that govern behavior and thought in communities, . . . there is always a broad range of other behaviors and beliefs that vary from individual to individual. The entire range of these behaviors and beliefs is available to all members of a community to adopt or ignore or even to invent new forms. Of critical importance is the notion that what determines which beliefs and behaviors will be adopted by most individuals is the perceived benefit that will be derived from adopting specific beliefs or behaviors [emphasis added] (Hayden 2003:17–18).

Under the “right” conditions, namely high levels of environmental stress (physical, environmental, and/or psychological) – shamanistic activity may result. The shaman, as we know, is often referred to as “the wounded healer,” experiencing a universal pattern of transformation through suffering, symbolic death, illumination, and rebirth (Hawkins 1984:191). We all have the birthright of woundedness and healing, regardless of our ethnic background.

**Proprietorship / Ownership**

Another pertinent issue is claims of “ownership” (be it a good, a resource, a concept, or land). There of course is an extensive ledger of indigenous peoples losing their land through colonialist takeovers. It is beyond the scope of this paper to review this history, but within this discussion it is important to note how land takings affected
shamanic practices. Loss of land sometimes not only meant loss of economic subsistence, but also loss of ritual sites, sense of place, and heritage. The antelope shamans of the Northern Paiute died out in the early 20th century after all their lands were taken over by white ranchers that caused the antelope to disappear (Park 2001:94–96).

When we speak of material goods or something that is concrete, it is easier to discuss the aspect of ownership. But when we speak of ideas and concepts, the issue of proprietorship gets a bit murky (the reason for patent laws for inventions, trade names, etc.). When we look at ownership rights from a global perspective, it becomes even more complex. Firstly, different things have different values/meaning to different people, and secondly, not everyone is operating under the same market system, or behaving relative to the same economic values. Returning to the example of the altiplano study of lung capacity conducted by a team of Western anthropologists, the value of extracted blood, body fat, or even expired air held a different biocultural meaning to the Quechua.

Cultural anthropologists face this dilemma as they probe daily life, social relations, medical practices, and ritual [of another group]. Knowledge, body measures, vital essences, and even photographic images removed from the community and used for unknown purposes by unknown people can be alarming to those being studied. Therefore, [researchers] need to think carefully and ethically about this extraction process, who it serves, and the extent to which it truly benefits the donors or some greater purpose (personal communication with R. Brooke Thomas).

The second point needs to be understood within the perspective of political ecology, i.e. the economic environment of contested and empowered resources. While Western countries evolved from a feudal system, to capitalism, to a transnational corporation (TNC) economy; indigenous communities have long operated under contrasting economic cultures based on low technology, subsistence resource extraction and consumption, and communalism. Thus when we move the entire world into a
corporate, globalized economy, those who operate under differing values (and with much smaller means) are at a disadvantage.

It is no small irony that the very reason native peoples have become such targets for the globalized economic juggernaut is because they have been so successful at sustaining cultures, economies, and philosophies that do not seek to exploit the natural world for individual economic advantage, or profit, or to ship resources to export markets (Mander 2005:3).

As was mentioned earlier, the patenting of plants, namely in seed form, inflicts a huge economic hardship on indigenous farmers (and farmers in the West as well). The case of Canadian farmer Percy Schmeiser has shown the lengths to which a large corporation will go to exert intellectual property rights via a patent.50 A patent application for ayahuasca was filed not too long ago, but then revoked.51 Imagine the impact such a patent would have on shamanic practice in Central and South America.

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50 Canadian farmer Percy Schmeiser was sued by Monsanto for illegally planting its patented “Roundup Ready” canola seed without the requisite contract and subsequently charged a technology fee of $15/acre. Schmeiser appealed saying that unbeknownst to him the seeds blew onto his farm from surrounding farms that grow the patented seed. The final decision handed down by the Canadian Supreme Court in May 2004 determined that Monsanto’s patent is valid, but Schmeiser does not have to pay Monsanto anything as he did not profit from the presence of Roundup Ready canola in his fields (http://www.percyschmeiser.com/conflict.htm).

51 In March 1999, the Center for International Environmental Law (CIEL) filed a legal challenge with the U.S. Patent and Trademark Office (PTO) on behalf of the Coordinating Body of Indigenous Organizations of the Amazon Basin (COICA) and the Coalition for Amazonian Peoples and Their Environment (Amazon Coalition) concerning a U.S. patent claimed on the “ayahuasca” vine, Banisteriopsis caapi, native to the Amazonian rain forest. COICA objected to the patent because it purported to appropriate for a U.S. citizen, a plant that is sacred to many indigenous peoples of the Amazon and used by them in religious and healing ceremonies. In November 1999, the PTO issued a decision to reject the patent based on the arguments that the claimed plant variety was not distinctive or novel; but did not acknowledge the argument that the plant's religious value warranted an exception from patenting (http://www.ciel.org/Biodiversity/ayahuascapatentcase.html).
Interest in shamanism by Westerners has triggered other impacts on indigenous communities as well. Tourism was mentioned earlier, and there are now many people making shaman-themed trips to indigenous communities to observe and study shamanic rituals and receive healing. This kind of venture provides economic input for the community, but it can also be a source of disruption and community tension. It inserts a capitalist mentality not previously employed [for example, see “Korean Shamans and the Spirits of Capitalism” 1996 by Laurel Kendall]. Granted, we might consider this merely another example of “modernization,” but can Westerners arrive into an indigenous community with sensitivity, with deep appreciation for its heritage, and without disruption? Some fear not. [for examples see Narby and Huxley 2001: Sabina and Estrada (1997) pp. 166–168; Brown (1989) pp. 251–256; de Rios (1994) pp. 277–279; and Ott (1995) pp. 280–285.]

Some have raised concern that as Westerners acquire shamanic healing knowledge and skills, while simultaneously these age-old practices die out in traditional communities, the “ultimate disgrace” for indigenous community members is they soon may be attending ceremonies performed by “white shamans” (Montejo 1999:61). Sadly, the reality is that the practice of shamanism has been dying out in many traditional communities, especially among today’s younger generation. Western media, consumer goods, and biomedicine, to name a few predominant examples of global influence, have changed prevailing traditional lifestyle practices.

For some communities, it is the presence of a Westerner revering their elder shamans that has helped renew an interest. U.S.-based organizations supporting the revival of shamanic practices in more traditional communities (both programmatically
and financially) include, but are not limited to, the Amazon Conservation Team, Dream Change, the Foundation for Shamanic Studies, and Spirited Medicine Alliance. Better yet, some indigenous communities are developing their own programs to reinvigorate an interest and training in local shamanic practices (Hervik 1992; Jackson 1995; Warren 1992); experiencing a revival on their own after political oppression has ceased (Balzer 2002; Vitebsky 2001:291–297); or experiencing an increased local demand for practicing shamans (albeit for reasons of negative influences by foreigners and modernity) (Kressing 2003). While the forces of colonialization and Westernization impinged upon traditional communities unarguably has been a major, if not the primary, cause of the demise of traditional shamanic practices, the world has reached a point in history where it may require a collaborative effort to revive shamanism, albeit in its transformative state.

It is no longer possible to make a watertight distinction between “traditional” shamanic societies (a mainstay of the old ethnographic literature and of comparative religion), and the new wave of neo-shamanist movements . . . For shamanism, as with any other kind of local knowledge, the essence of globality today is that it belongs both in the past of remote tribes, and in the present industrial subcultures. But there are further twists: the shamanic revival is now reappearing in the present of some of these remote tribes – only now these are neither remote nor tribal (Vitebsky 2001:292).

The obvious effort is to respect the sanctity of each community’s practice and somehow leverage economic gain incurred by one party at the expense of another.

**Spiritual Sensitivity / Sacredness**

A third aspect to consider in the issue of appropriation of knowledge is sensitivity to the spirits and an imbued sacredness attached to a particular ritual or practice. However, this lies less in any kind of legal/policy framework and more in the realm of personal ethos. As we know, many shamans throughout their traditions have worked with the dark side or acted with less than full integrity. Thus it is no different now than
before that each person who chooses to practice a form of shamanism must discern their intentions and decide which spirits to work with and how.

An anthropologist working in South America once relayed a story about an indigenous community that was discussing whether to raise and sell some of their local plants to a multinational corporation for processing and sale in the cosmetic industry. While many members of the community were in favor of this arrangement because of the promised income, the story goes that the community shaman was opposed. And his reason was that no one (except himself) had asked the flowers. The shaman stated that the flower spirits had concerns about working beyond their indigenous locality and the synergistic effects of mixtures not ever concocted before (personal communication with now-deceased anthropologist Darrell Posey). Thus when anyone works with the spirits of other beings, as most already may realize, there is a needed ethic of reciprocal exchange and communication.

Another concern raised is the locality of spirits being “called in” (i.e. called to be present or participate in the ritual). Some have noted that they feel it is inappropriate for a Western shaman to say, “call in” the volcanic mountain gods of the Ecuadorean Andes when performing a ritual in New York State. A more appropriate approach would be, for instance, to contact the spirits of the Catskills. With respect to personal practice, this may be a “private” matter between the practitioner and his or her helping spirits. We might consider the fact that if the volcanic mountain spirits of the Ecuadorean Andes do not want to work with someone, they probably will not show up. And the most likely ill effect will be the ineffectiveness of the practitioner’s ritual. However, if a Westerner is advertising themselves as a bonified Andean shaman, and profiting from fees charged for
healings and workshops, then this is what might be viewed in Western legal terms, a violation of a trademark. How this act is legally monitored is still in question, but worth further consideration.

**Conclusion**

The primary goal of this essay is to prompt more analysis and reflection on an issue that relates to human evolution, cultural sensitivity, cultural preservation, global markets, profit, and personal woundedness and healing. It is hoped that the reader will comprehend the argued delineation between the universal ability/right to practice (neo)shamanism and acts of appropriation that inflict loss. Neo-shamanic practice in the West is no less authentic or appropriate in its own right, and inherently does not “steal” from an indigenous community. We all are born with the capacity for shamanic activity and if certain individuals choose to study and/or access this ability, they are following in the footsteps of their very early ancestors (albeit a recess of a few thousands years of practice for some!). But when we insert the profit motive, the free trade market system that takes precedence at this point in time in our global history, inequities often emerge. And this is where appropriation becomes problematic. At present, neoliberal globalization has been deemed the primary force of demise for indigenous peoples (Tauli-Corpuz 2005b:185). Fortunately, policy analysts, activists, and indigenous leaders are coming together to find means with which to leverage indigenous rights in a global economy. We recently reached the end of the “United Nations (UN) International Decade for the World’s Indigenous People.” The UN is now extending this to a second decade (2005-2015).
Some believe shamanism must be secured in the local and should never become a system of globalized knowledge, such as Western science. But others are working toward a new collaboration of Western science and indigenous knowledge, information and wisdom, the eagle and the condor flying in convoy.\(^{52}\) Shamanic practice may evolve in a “new age” to address new problems not previously encountered by the human condition. “Globalization may lead either to the downgrading and abandonment of indigenous knowledge, or on the contrary to its reassertion and transformation” (Vitebsky 2001:292). Connie Grauds, founder and director of Spirited Medicine Alliance, believes in the need for reciprocity. “What we need in the North is the spirit, the soul, the shamanism, and the indigenous wisdom. What they [developing countries] need is our [Westerner’s] technology, medicine, know-how, and money. But it has to be reciprocal” (personal interview).

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\(^{52}\) Comment by an Amazonian shaman, meaning that now is the time for the people of the rain forest (embodying spirit-based healing wisdom) and the people of the United States (advocating scientific-based healing knowledge) to share and collaborate with their approaches to healing (Sinnott 2001:241).
CHAPTER 9
CONCLUSION

[We have reached] a time when the shamans of the traditional world are increasingly the focus of two contradictory trends. On one side we have, as the by-product of headlong destruction of tropical environments, an unprecedented assault on their very survival. And if shamans and shamanism disappear, with them would go irreplaceable stores of empirical knowledge and experience – the special expertise of shamans in the natural environment, which could ultimately benefit all of humanity.

Against this potential disaster, the dimensions of which are becoming apparent only now that it is almost too late, we see an upsurge of interest in, and a new respect for, shamanism as a phenomenon of religion (Furst 1994:1).

The previous eight chapters have outlined anthropological research regarding the “upsurge of interest” in shamanism in the West, via ethnographic interviews and observations within the biomedical framework of practiced medicine in the United States. Attention has centered on the manner in which traditional shamanism has been studied, transformed, and applied to Western approaches to healing, though not without some degree of address to the concerns of indigenous cultures from which traditional shamanism was borne, especially with respect to the question of appropriation (as discussed in chapter 8). As expressed in anthropologist Peter Furst’s introduction to his own treatise on shamanism, quoted above, as well as similar statements made by many others interested in the field of shamanism, there is a common belief that the practice of shamanism could prove beneficial to “all of humanity.” Thus through the lens of a changing dynamic in the field of biomedicine, this study has attempted to investigate the application of shamanic principles and techniques as it is applied to evolving Western notions of healing.
Summary of Findings

Chapters 4-6 presented data collected via surveys, interviews, and ethnographic observation followed by chapter 7 in which two levels of analysis were provided: one subcultural in which I compared the Individual Model with the Collaborative Model as practiced in the United States; and the other cross-cultural, in which I highlighted differences between the practice of neo-shamanism in the West with traditional shamanism(s). Here is a summary of my findings:

* The Collaborative Model as it is defined in this study appears to be more successful in allowing the full expression of shamanic practice within an established medical setting. The two shamanic healers at True North, Allie Knowlton and Evie Rysdyk, receive the benefit of working within an established health care center, but outside the limitations of professional medical associations that instill barriers to and fears regarding the overt practice of shamanic healing.

* The practice of shamanism in Western medicine in the United States looks different from the practice of shamanisms in traditional shamanic societies. Many of these differences are a result of distinct cultural aspects of a modern, Westernized society, namely: emphasized individualism; privacy/privatization; commodification; formalized legal institutions; and a utilitarian relationship to the natural environment.

* While a small number of individual practitioners expressed comfort with practicing shamanic healing within their professional health care practice, the majority of interviewees discussed concerns and reservations in the following categories:
legal, financial, status and reputation, and cultural acceptance, specifically collegial and patient/client.

* Some Western-trained health care practitioners have limited or remained covert in their shamanic practice; but others have found means through which they have been able to adapt their professional medical services to include some overt expressions of shamanic healing. In a few cases, individuals have been able to instill greater awareness and acceptance of shamanic practices within their medical institution of employment.

* Medical practitioners who have studied and adopted shamanic healing techniques have experienced personal benefits as well as positive shifts in their medical services, such as greater ability to listen and empathize with their patients, enhanced diagnostic skills, and the offering of support services to patients who are suffering and/or dying.

* Western-trained medical practitioners have experienced shifts in their personal worldview and professional approach to healing; however, they still function to a degree within the attitudinal framework of biomedicine and Western cultural tenets. Their application of shamanic healing precepts and techniques tends to be more for emotional/spiritual support and less for biological healing and thus allopathic medicine still serves as their primary modality of healing. However, it should also be noted that unlike the biomedical model that strictly attends to the physical body, most practitioners interviewed tended to acknowledge a direct relationship between the physical, emotional, and spiritual body.
* Personal healing is the primary motivation for practicing shamanic techniques and central to its adoption in the West. While traditional shamanism(s) emphasizes balancing the energies of the environment through healing the individual–community–environment relationship, with individual healing being a more precipitous result; the practice of Western shamanism has focused on and emphasized personal healing, with societal and environmental healing being an addendum or later development to the process.

**Further Considerations**

As was referenced in earlier chapters, there are difficulties in measuring the efficacy of alternative methods of healing, in part because to begin with, there is preemptory difficulty in defining the term (Waldram 2000). Furthermore, during my interviews with MDs, reference was made to the argument that even efficacy studies within biomedicine are difficult. Neuroscientist Candace Pert states in her text *Molecules of Emotion: the Science behind Mind–Body Medicine* that “much of mainstream medicine itself is totally unproven – yet we do it anyway. . .  [and] that we are holding alternative therapies, those that use mind–body and spiritual techniques, to a higher standard than we apply to mainstream medicine” (1977:308). Pert also argues from her personal experience and scientific research that “the soul, mind, and emotions [all] play an important role in health” and that there is a need to expand the field of biomedical science to counter the Cartesian theory of body–soul separation (p. 304).

As has been discussed throughout this study, one important role of shamanic work is attendance to the soul aspect of an individual. Cecile Carson, MD states that “illness often demands soul-level work to effect healing, yet most clinicians are trained to view
addressing only biomedical and [sometimes] emotional aspects of a patient as constituting complete care” (January 2006 (unpublished):1). In April 2004, a keynote address entitled “The Soul of Medicine” was delivered by alternative healer, Deena Metzger, to the American Holistic Medical Association (AHMA). Though still a separate entity from the much larger and more established American Medical Association, the founding of the AHMA (1978) speaks to the growing interest and medical practice of alternative and complementary therapies. Metzger advocates the need for acknowledging the “soul of medicine” and the role of physician as “healer” (p.1). She also posits a physician’s need to view illness as “a process through which meaning replaces random suffering, through which someone can be transformed . . . “ (p.7). This is reflective of the shamanic approach in which the question of “why” rather than “what” is raised with respect to a person’s ailment or injury. Metzger concludes her address with the point that healing is not necessarily about achieving a state of physical health nor restoring an individual to his or her original condition, but rather “healing is helping to align the individual with the trajectory of the soul” (p.17). Although Metzger’s speech does not segue into discussions on scientific studies of medical efficacy, the point here is to realize that soul-level healing does not always equate with biological repair, thus a strict biomedical approach to measuring the “success” of shamanic healing is limited.

David Cumes, MD published an on-line article on the SSP website, “A Sangoma/Surgeon’s Look at Shamanism” (August 2007) in which he compares the “contradictory polarity of healing” between the shamanic approach and the “modern allopathic paradigm.” He states that the shaman “embraces mystique rather than methodology, the compassionate and the empathetic rather than the objective and
impersonal, the intuitive rather than the rational” and that “shamanic techniques are a part of healing that has been almost totally ignored by Western medicine” (pp. 2–3). Granted this is a Westerner’s perspective on what shamanic healing encompasses, but it represents the comparative notion from a Western medical perspective. Cumes also notes the contrast of initiation in which an individual may become a shaman as a result of a psychological or physical wound whereas the average Western medical student may enter medical school without any “overt” wound, but ends up wounded due to the arduous and depersonalizing biomedical training that must be endured. “The doctor’s wound is secondary rather than primary. . . [which] often dilutes out the ability or the desire of the physician to be compassionate” (p. 2).

The growing request for and practice of shamanic healing in itself may serve as a marker of efficacy on a level that may not be scientifically empirical, but is culturally effectual. Anthropologist Bill Brunton, and previous editor of the FSS journal *Shamanism* states that “there is a plethora of shamanic organizations, and the number of people trained in [FSS] workshops alone numbers in the many thousands. Practitioners can be found worldwide, and in the United States, in nearly any community of any size” (2007:1). World-renowned shamanic teacher/trainer Sandra Ingerman stated in her interview that the number of physicians attending her workshops has increased radically in recent years.

Previous discussions, especially those presented on “The Individual Model” in chapter 4, noted the ongoing tensions between the practice of shamanic healing in the United States by non-medically-trained healers versus Western-trained medical practitioners. For some individuals, the combining of Western medicine and shamanic
healing may be viewed as a sacrilege and/or too great a contrast of healing approaches. However, as one of the interviewed DOs noted, the means by which to validate shamanic healing for the American public may be through its practice within the establishment of Western medicine, rather than as a stand-alone therapy, adding that physicians are still perceived as high-status professionals in the United States (Stan, DO). This study clearly presented many of the barriers of practicing shamanic healing within a biomedical framework of institutionalized medicine; yet through the interview process, it also became apparent that there are many examples of successful merging, or at least cojoining, of the two disparate modalities. As a result, a syncretic form of healing has emerged.

In the comparative analysis of the “Individual Model” with the “Collaborative Model” demonstrated at True North Health Center, it also is clear that the latter model presents fewer institutional barriers. As was discussed in chapter 7, the True North shamanic healers have a unique position in which they sit outside of the medical associations that inflict innumerable barriers upon the practice of shamanic healing; and yet at the same time they are affiliated with an established health care facility that also houses Western-trained physicians and other certified health care practitioners, thus enhancing their own credibility among the general populace.

While the study of shamanic healing has greatly supported and expanded the practice of “healing” by Western-trained medical practitioners, as personally expressed in many of the interviews, the True North model may allow for a more open, overt practice of shamanic healing within a medical framework at this point in time in the United States. As other health care facilities adopt this same model (which may occur in the near future
based on the large number of requests received by True North for organizational consulting advice), this model may allow for a greater receptivity of shamanic healing approaches within the medical establishment over time. Furthermore, the practice of collaborative medicine may be a growing model within the health care industry with respect to many subfields of medicine. A recent article in the journal *Integrative Medicine* discusses the need to move beyond “integrated” care in which the physician is “the sole provider and determiner of health care” to “collaborative” care that “utilizes the full spectrum of all competent licensed providers of health care services.” The article notes that while some practitioners have been able to engage in self-study and practice of CAM therapies, their numbers are small and their abilities somewhat limited (Shepherd 2004:17).

In terms of the demographics of those receiving shamanic healing in the United States, many are middle to upper-middle class whites. However, as shamanic healing becomes more prevalent, the demographics of this recipient group may expand in terms of income brackets. As noted, True North participates in the Maine Time Dollars program that works via a barter of services exchange; and has established a private fund for low-income clients. There is also a credo within the shamanic healing community that no person shall be turned away who is in need of healing services, regardless of their ability to pay. This is an ethical understanding, rather than an institutionalized requirement, but Sandra Ingerman has stated that she will remove any listing for a shamanic healer that she learns subverts this credo (and her website is a much-accessed resource for healer listings).
It also should be mentioned that the expansion of shamanic healing may benefit immigrant and indigenous populations living within the United States. Although one of the interviewed MDs described her work with immigrant populations (specifically Mien and Khmu of Laos) and their culture’s tradition of shamans being male, rather than female, she went on to describe her ability to support their traditional healing efforts in other ways (Linda, MD). World-renown shamanic teacher/healer Sandra Ingerman, who resides in New Mexico, stated that she has worked with many indigenous clients who do not have access to a traditional healer (personal interview). Thus, the greater cultural acceptance of shamanic healing within the dominant culture of the United States may in turn support the needs and traditional practices of U.S.-based indigenous groups as well as immigrant populations that are establishing themselves throughout the United States.

Revival of shamanism in other parts of the world is also taking place, often in communities where traditional shamanism has receded or died out due to political oppression, biomedical hegemony, or other aspects of development. With particular reference to the global movement of biomedical hegemony, there is a need within the international community to equalize respect for ethnomedicine with biomedicine. While the field of anthropology, especially CMA, has shifted preconceived concepts of “primitive knowledge” to a greater recognition of the subtle complexities of ethnomedicine, development discourse and the field of biomedicine continue to view empirical science as a necessary hierarchical approach to medical development (Greene 1998:636). In the analysis of a case study of an Aguaruna shaman in Peru who

53 The FSS journal “Shamanism” published a 25th Anniversary Double Issue in which it includes a series of articles on FSS’ outreach work and the revival of shamanism in traditional cultures (Bill Brunton, ed. 2005, 18:1&2:71-121).
incorporates the use of needles and pharmaceuticals into his healing protocol, anthropologist Shane Greene (1998) argues that the shaman’s practice exemplifies what the author calls the “shamanizing” of science—in contrast to efforts to “scientize ethnomedicine” that are implicit in exploitative development ideology. In other words, this hybrid approach does not represent an act of biomedicine “modernizing” an otherwise stagnant and primitive healing practice, but rather a collaboration of two viable and equally valuable healing modalities. Thus in the United States, the adoption of shamanic healing techniques may be viewed as the “shamanizing” of biomedicine rather than the “scientizing” of shamanism.

Another key point that was made in the analysis of adopting shamanic healing in Western medicine in the United States is the comparative motivations and application of healing between traditional shamanic cultures and those practiced by Westerners in the United States. As was argued in chapter 7, while traditional shamanism focused on healing imbalances between the human and non-human worlds (e.g., plants, animals, and spirits), the practice by Westerners often, though not always, appears to be directed toward the healing of individual persons, whether physical, emotional, or spiritual. As was noted, some of the leading Western teachers of shamanism stated their workshops and trainings addressing the healing of the environment were in much less demand than those advertising topics addressing personal healing. They philosophized that through the process of individual healing, people would then turn to address greater needs of society and the planet.

Deena Metzger in her earlier-referenced address to the AHMA in 2004, states to her audience that “now we are required to go another step and see that in healing the
patient we are given the opportunity to treat the world as well.” Metzger hypothesizes that many of today’s illnesses “are analogous to societal and global ills and so in treating the individual we are being trained and called to bring healing to the society at large” (p.3). At a “Shamanism in Medicine” conference in Sante Fe, New Mexico in May 2004, workshop leader Sandra Ingerman stated: “We’ve been practicing ‘Newtonian’ shamanism in the West in recent times and now we need to move to a ‘quantum physics’ shamanism,” explaining that Isaac Newton believed everything was separate. In a published interview with Ingerman, she described the personal transformation that a person experiences when they take up the practice of shamanism as follows:

I think one of the biggest transformations involves the theme of remembering the truth of who we are. Quantum physicists discovered back in the 1940s and 1950s that there is no separation. It’s an illusion that we think we are separate forms – we are connected to what both quantum physicists and shamans call the web of life. So when people start to practice shamanism, they realize that the perception of themselves as separate is an illusion and they get back to feeling a connection with the web of life. I am connected to the trees that live outside, and I am connected to the earth, the air, water, and fire. This causes a transformation in and of itself. And as people proceed in their shamanic practice, they keep going deeper, and deeper, into that understanding of being connected to a field of energy which is incredibly powerful (Horrigan 2003:80).

Given that the sense of connection to the earth and nature may be a more common cultural belief system among many traditional societies, as argued earlier in this study, it may be the emulation of a nearly-eradicated religio–spiritual practice that fortifies this perception in a modern, Western society. As has been clearly shown, the traditional practice of shamanism has been greatly revised to adapt to a very different cultural context than that of a small, subsistence-based, communal society, but it nonetheless has carried forth long-held traditional tenets of shamanism.
As I noted back at the beginning of chapter 2, more recent studies within the field of CMA support the understanding that culture drives the practice of biomedicine rather than the other way around. The adoption of shamanic tenets and techniques among Western medical practitioners in the United States speaks to this finding (though the platform of biomedicine is certainly a profound force within this syncretic adaptation). Within the context of the studied subculture of the Western medical community in the United States, shamanic healing practices are reshaping the definition of ‘healing’ and the manner in which health care is prescribed. It may be occurring in tiny pockets, even simply in isolated one-on-one clinician–patient relations, but there is no question that it is indeed taking place. The impact of shamanic practices is both affecting the provider as well as the patient, which in turn may result in a broadening ripple effect. As one MD wrote, “as shamanically-trained clinicians, we have endless possibilities in alliance with the spirits to become more whole ourselves, and then to be available in service to our patients” (Carson, January, 2006 (unpublished):15). And the hope is, service as well to the community, the environment, and the planet.

**A Note from the Investigator**

It would be remiss for the investigator of this study not to acknowledge her own participation in the study and practice of shamanism. My experience at shamanic workshops, extended trainings, and ritual events have certainly colored my analysis of shamanism in the West; however, more as a backdrop to my specific study of the adoption of shamanic healing in Western medicine, rather than a direct source of data. As noted in an article on psychedelic mushrooms and consciousness published in a recent
Anthropology of Consciousness journal, the author writes in regards to his own practice of “myco-spirituality” over the last fifteen years:

While until recently such an admission might have stripped me of all academic credibility, being a practitioner of a particular spirituality is no longer considered to be the obstacle of scholarship that it once was. Briefly, postmodern critiques concur with Foucualt that all observations are made from somewhere, and that there is no privileged position outside discourse (Letcher 2007:78).

As the investigator, I not only have studied and practiced shamanic healing techniques, but I also have practiced other religions during my lifetime, and have participated in Western medicine as a patient (as well as experienced other alternative healing therapies), and have been born and raised in the dominant white, middle-class cultural milieu of modern United States. Thus there is no ability to remove myself to a place of complete objectivity when conducting a cultural anthropological investigation, as is now recognized within the doctrine of postmodern anthropological theory.

There is debate about whether an anthropologist should sit within or outside the subject that they are studying. Anthropologist Andrei Znamenski discusses this concern in his text on Western shamanism. He concludes that while “some explorers of the sacred feel uncomfortable about such dancing between mainstream academia and the ‘reality of spirits’,” Znamenski states that he is “personally convinced that being in the middle ground is precisely what provides the most valuable insights” (2007:211).

Given that the subject of this research also situates itself in “the middle ground” between the traditional (shamanism) and the modern (field of biomedicine), it may be beneficial that the investigator also juxtaposes herself between traditionally-rooted practices and habitation in a modern culture. To the best of my ability, I hope that I have aptly presented my analysis and fairly represented the many individuals who offered up
their personal thoughts and experiences on which I base much of my conclusions; and that my personal exploration into the spirit world has broadened, rather than blurred, my overall expose on a small, but emerging movement in the United States.
ABBREVIATIONS

AHMA – American Holistic Medical Association
CAM – complementary and alternative medicine
CMA – critical medical anthropology
DDS – doctor of dental surgery
DO – doctor of osteopathic medicine
FSS – Foundation for Shamanic Studies
GDP – gross domestic product
HIPAA - United States Health Insurance Portability and Accountability Act of 1996
IK – indigenous knowledge
MD – medical doctor
NCCAM – [National Institutes of Health] National Center for Complementary and Alternative Medicine
ND – doctor of naturopathic medicine
NOR – non-ordinary states of reality
OR – ordinary states of reality
OSC – ordinary state of consciousness
PA – physician assistant
RN – registered nurse
RPH – registered pharmacist
SSC – shamanic state of consciousness
SSP – Society for Shamanic Practitioners
TEK – traditional environmental knowledge
TN – True North Health Center

UNEP – United Nations Environment Programme
Western medicine is in dire need of healing, especially of its Spirit. Many Western-trained practitioners of medicine have come through the training programs of the Foundation for Shamanic Studies over the past 20 years – yet there has been no systematic look at whether or how these principles and practices of shamanism are being used in medical settings. This survey is an attempt to collectively understand how shamanic resources may be being translated into more traditional healthcare settings (office, clinic, hospital), and then to share this information and practical ideas with each other, to enrich the possibilities for us all. Please fill it out, even if you are presently not using shamanic principles in your work, to make the survey as complete as possible.

THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

Although this is not a formal Foundation project, the Foundation plans to report on these responses to the FSS membership through its journal Shamanism. A preliminary report is planned for the second annual Shamanism in Medicine conference, cosponsored by the Foundation and by Alternatives Therapies in Health and Illness in Santa Fe, NM, in 6/03.

Name (optional) _____________________
Address (optional) ________________________________________________________ _________________________________________________________
Phone (optional)__________________ email (optional)______

Professional Degree: _MD_DO_DDS_DC_RN_PsyD_MSW_PharmD_OT/PT_Other

Brief description of your Western medical training:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Please describe your present work setting:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

_______________________________________________________________________
Shamanic training you’ve had with the FSS (check all that apply):

- Basic Workshop ____
- Shamanic Extraction____
- 6-week Follow-up to Basic_____ Death, Dying and Beyond ____
- 2 week Intensive______ Spirits of Nature____
- Soul Retrieval ____ Shamanic Counseling____
- East Coast/West Coast 3 Year Advanced Program ____

Other Shamanic Training:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are you able to integrate your shamanic training into a Western medical setting?
Yes____  No____
Overtly____  Covertly (attitudinal? at a distance?)____

Please explain briefly how you experience and/or practice any integration. (Feel free to include specific examples. Use the back of the page or additional page for extra space.):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please return this form to Cecile Carson, MD, 234 Clovercrest Drive, Rochester, NY 14618. Address any questions to her at (585) 271-5650 or ccarson4@aol.com.

Thank you!
February 8, 2005

Dear Shamanism in Medicine Survey Respondent,

A while back you completed a survey on integrating shamanic principles into Western medical practice and returned it to me with your name and contact information. Firstly, I would like to thank you for taking the time to fill it out and share your thoughts and experiences.

There seems to be a lot of exciting activity in healthcare practitioners’ efforts to incorporate shamanic healing into their medical practices, and I feel that it is very important to document what is taking place. In an effort to better collect and analyze data regarding this process, I recently began collaborating with an anthropologist from the University of Massachusetts, Lori Thayer, who is writing her dissertation on the adoption of shamanic healing into Western medicine. I have shared the surveys with Lori, and together we are working to move the project forward. Please be assured that your survey responses continue to be kept confidential and secure between Lori and me.

We are now in the process of tabulating the survey results and then hope to follow up with more in-depth interviews. Either Lori or I may be contacting you in the near future to see if you would be willing to be interviewed, either in person or via telephone. We hope that you will be interested in contributing to the analysis of a very significant phenomenon taking place in our culture. Once again, we would do this in a way that would be kept confidential.

In brief summary, the 100+ surveys that we received display a range of responses in terms of respondents’ medical and shamanic training, as well as use and degree of comfort with practicing shamanic healing techniques. Some of you are using your shamanic training overtly in your clinics and hospitals, while others are still searching for an appropriate means and place of application. We would like to think that each of you may gain greater insight from each other’s shared experiences; and that many others in varying stages of studying and adopting shamanic healing will also learn from this exploration and discussion of such an important movement in the field of western medicine. Our hope is to publish the results in Shamanism, the journal of the Foundation for Shamanic Studies, as well as on the Society for Shamanic Practitioners website.

We look forward to talking with you soon. In the meantime, if you would like to get in touch with us, our contact information is provided below.
Again, thank you for your efforts and participation.

Sincerely,

Cecile A. Carson, MD
ccarson4@aol.com

Lori Thayer, M.A.
27 Crescent St. #1
Northampton, MA 01060
thayer@anthro.umass.edu
APPENDIX C

HUMAN SUBJECTS REVIEW

To: Lori Thayer  
From: Art Keene  
Subject: Human Subjects Review  
Date: March 7, 2005

I have reviewed the Human Subjects statement that you have submitted for your dissertation research, “The Adoption of Shamanic Healing Techniques into Western Medicine” and find it acceptable. You may now begin the human subjects portion of your research.

Best wishes with your research.

Art Keene

The University of Massachusetts is an Affirmative Action/Equal Opportunity Institution
January 24, 2005

RE: Human Subjects Review

Dear Art,

I am writing to request approval for my Human Subjects Review proposal for my dissertation research on the adoption of shamanic healing into western medicine. Attached is a copy of my research protocol. I intend to begin the interview process as soon as your approval is granted.

Through collaboration with Dr. Cecile Carson, who serves on my dissertation committee, a set of surveys has been collected (respondent’s name and contact information were voluntary) regarding the study/use of shamanic healing techniques by western-trained healthcare practitioners. As a follow-up to the surveys, my intent is to contact each respondent and conduct a personal interview, either in person or via telephone, or in rare cases, email. Respondents live in states throughout the United States, so the means of contact will vary.

The proposed data collection is strictly qualitative, and non-invasive. The research poses no risk to any of the participants, all collected information will remain confidential unless explicit permission for public presentation is granted, and I commit to adhering to all standards for researchers set forth in the Code of Ethics of the American Anthropological Association.

My main source of data collection for my research is through surveys and personal interviews. The study group will include: 1) western trained healthcare practitioners; 2) clients who have received shamanic healing; 3) medical students who have taken a course on shamanic healing; and 4) staff of organizations teaching shamanic healing techniques in the United States.

Please let me know if you need any additional information from me in order to approve this project.

Sincerely,

[Signature]

Lori Thayer

attachments
Research Protocol

Prospectus:
The Adoption of Shamanic Healing Techniques
into Western Medicine

by
Lori Thayer

The goal of my research is to investigate why and how shamanic healing techniques are being studied and incorporated into western healthcare settings in the United States; and to identify the emerging hybrid form of healing that may be developing at this time. The researcher hopes to unearth underlying reasons why both healthcare practitioners and patients are seeking the use of an ancient, non-western healing methodology; and conversely, the barriers to doing so in traditional western healthcare settings, such as clinics and hospitals.

My principal methods of data collection, apart from possible ethnographic observation and anecdotal evidence, will be surveys and interviews.

Surveys were initially distributed by committee member, Dr. Cecile Carson, and respondents returned completed forms to her. I will be following up on respondents who voluntarily identified themselves, requesting personal interviews via in-person, telephone, or email. Prior to conducting the interview, I will ask each interviewee to read and sign an informed consent form (copy attached). I will ask permission to tape the interview. All materials on paper and tape will be kept in a secure place and confidentiality will be honored. Collected personal information will be published in my research anonymously, under a pseudonym, or in aggregated form.
INFORMED CONSENT FORM

Informed Consent Form
Study on Shamanism in Western Medicine

This interview is part of my research in the doctoral program in cultural anthropology at the University of Massachusetts, Amherst. The study concerns the study and practice of shamanic healing techniques and their incorporation into western medicine. This portion of the research consists of interviews with practitioners, patients, students and teachers of shamanic healing techniques in the United States.

Your participation in this interview is completely voluntary. You may decline to answer a question, if you so choose, and you may terminate the interview at any time.

All information you provide will be kept confidential. Your name will not be used in connection with any publication related to this study, unless explicit permission is granted by you; and all provided information will be disclosed in a manner to ensure anonymity.

I will ask your permission to tape record this interview, to ensure accurate chronicling of your responses. You may decline permission if you so choose. After transcription, the audiotapes will be erased.

Please sign below to indicate that you have read and understand this consent form.

Lori L. Thayer
Department of Anthropology
UMass Amherst

The study has been explained to me, and I have had my questions about it answered. I understand that there are no risks associated with participating in this study, nor penalties for not participating. I have read and understand this consent form, and I acknowledge receiving a copy.

______________________________
Study Participant

______________________________
Witness/Interviewer

______________________________
Date
APPENDIX D

INTERVIEW QUESTIONS FOR WESTERN-TRAINED MEDICAL PRACTITIONERS

Interview Questions for Western-trained Medical Practitioners:

- What is your medical background? Education? Practice?
- What made you decide to enter the medical profession?
- When did you become interested in alternative forms of healing? Shamanism specifically?
- Did your formal medical education offer you any training in alternative medicine/shamanic healing?
- What training have you had in shamanic healing? Describe.
- What does shamanism mean to you?
- Did you have any kind of shamanic initiation experience?
- Have you incorporated shamanic healing into your treatment protocol? Why or why not? How?
- What barriers have you found to adopting shamanic healing techniques in your practice? e.g. colleagues, institutional? clients? friends and family? societal?
- How have you broached the use of shamanic healing with your clients? overtly? covertly?
- Are your colleagues/institutional employer (if any) aware that you are practicing shamanic healing? Why or why not? Their reactions?
- What do you see as the key differences/similarities between western biomedicine and shamanic healing?
- Do you feel that the medical community is becoming more open to the use of shamanic healing? Why or why not? Examples?
- What are your thoughts on non-medically trained shamanic healers versus formally-trained medical practitioners who also studied shamanic healing? Would you like to see some sort of institutionalized certification?
- Do you charge additional fees for shamanic work? Would you like to see shamanic healing covered under health insurance policies?
- Do you have any thoughts on cultural changes that may be taking place in the medical health care system in the U.S. with regards to the practice of shamanic healing? In the broader cultural context?
- Has your study of shamanic healing affected other aspects of your life besides professional?
- Has the process of studying and practicing shamanic healing affected you personally in terms of your perspective on life and societal issues?
- Do you want to continue your training in shamanic healing? How might you do that? i.e. Where do you go from here?
June 20, 2005

Evelyn Rysdyk
True North
202 U.S. Route One
Suite 200
Falmouth, Maine 04105

Dear Evie:

It was great to meet you and participate in your session at the Society for Shamanic Practitioners in California held recently. I had heard a lot about True North and had hoped to talk to you about possibly conducting some ethnographic research at the clinic. As you suggested at our lunch meeting, I am enclosing materials for you to review regarding our discussion. Enclosed you will find: 1) a proposal to conduct ethnographic research at True North; 2) a summary of my dissertation research; and 3) my CV.

Please let me know if you have any questions or would like any other information. I would be glad to come and meet you and/or other staff members to discuss this in person (as I always appreciate an excuse to get to the Maine coast!). I hope that we can find a way for this proposal to benefit everyone involved.

Looking forward to talking with you again.

Sincerely,

Lori Thayer

Enc.
Proposal: Ethnographic Research at True North, Falmouth, Maine
Researcher: Lori Thayer, Department of Anthropology, UMass Amherst

Research Objective: The intention of conducting research at True North is to observe ways in which shamanic healing is being accepted and incorporated into western health care, as well as encountered barriers and limitations. Data collection and information regarding this research is specifically for the purpose of writing an academic dissertation, and is not intended for any self gain or profit.

As a model of health care service that complements shamanic healing with western medicine, I would like to propose that True North serve as a case study in the analysis of western medicine’s adoption of shamanic healing practices. While a small, but growing cadre of western trained health care providers are studying and practicing shamanic healing techniques in combination with their biomedical services, True North provides a unique model in its method of offering complementary medicine to its clients – through the complement of biomedically trained staff with various alternative healers, including shamanic practitioners. The work of True North may promote a new model of health care services as well as shed light on changing attitudes regarding the public’s acceptance of shamanic healing practices. Thus, True North provides a ripe ethnographic site for better understanding how shamanic healing is being accepted and incorporated into western health care services.

The field of cultural anthropology uses a research method called participant-observation whereby the anthropologist both observes and participates in the cultural group being studied. I would like to propose that I might work at the True North clinic in a similar capacity as that of a resident intern. In this way, I would observe the work of staff at the clinic while also participating in whatever activities were deemed appropriate. I am open to a timeframe and schedule that works for the clinic staff.

In an effort to study the adoption of shamanic healing into western medicine, I have a background in medical anthropology as well as shamanic healing work. I am a member of the Society for Shamanic Practitioners; I have taken workshops with Michael Harner, John Perkins, and other lesser-known healers; and I have attended the second and third annual “Shamanism in Medicine” conference in Santa Fe, New Mexico and the Society for Shamanic Practitioners conference in California this June.

Human Subjects Review/Confidentiality: My dissertation research has been reviewed by the Human Subjects Review Coordinator within the Department of Anthropology at UMass Amherst. I have developed a Human Subjects form regarding confidentiality that must be signed by anyone that I interview. I am aware of the need for confidentiality when interviewing subjects or collecting data such that explicit permission will be sought before any information is published if it is of a personal nature.
**Personal Statement:** My interest in this research topic is the hope of documenting ways in which western culture is experiencing a shift in mainstream attitudes regarding definitions of health and healing and opening to ideological frameworks beyond hegemonic notions of western science. I also hope that this dissertation will help bridge western and non-western cultural frameworks within academia itself. This may allow the expansion of belief systems practiced within a western cultural framework, fostering greater awareness for the need for cultural (as well as biological) diversity within a global context.

**Service:** I am open to offering some form of in-kind service in exchange for an opportunity to serve in the capacity of a research intern at True North. Suggestions that would meet a need at True North would be welcomed. I also will share my research findings with True North, and provide a final copy of my dissertation.
Dissertation Research:  
The Adoption of Shamanic Healing into Western Medicine  
by  
Lori Thayer  
Department of Anthropology, UMass Amherst  

Summary  

Through cultural anthropological analysis, this dissertation research will investigate the adoption of shamanic healing techniques into western medicine that presents a new hybrid modality of health care shaped by two disparate healing traditions. Contrary to the biomedical model, Shamanism, a religio-spiritual practice, includes the spirit world in its process of diagnosis and healing, and seeks to achieve a balance between the individual, his or her community, and the environment. As westerners turn to shamanic practices as a source of healing, this study will examine the ministering of western medicine that includes shamanic healing, the broader cultural implications, and ethical concerns relative to the appropriation of indigenous knowledge. Specifically, this study will focus on the shamanic training and practice of western health care practitioners, patient/colleague/administrative responses, and new models for offering complementary health care services. Data collection via surveys, interviews, and ethnographic observation will provide a means of analysis of changing western cultural notions of illness, health, and healing relative to the individual and their social world and environment, and within the context of an organic as well as a spiritual dimension. The overriding questions are: “How does the practice of shamanic healing techniques influence western medicine?” and “How does western culture reshape the ancient practice of shamanic healing?”  

Background  

As the U.S. populace increasingly turns to alternative forms of healing in conjunction with or in lieu of classical biomedicine, shamanic healing has been added to the list of unconventional therapies in demand. Shamanism is purported to be the oldest healing modality, dating back to Siberia some 12,000 y.a., and is or has been practiced in various cultural forms throughout most of the world. However, the healing paradigm of shamanism has been rebuked by the western world for hundreds of years due to opposing belief systems of monotheism and reductionist science, when more corporeal views of the body took hold in the field of medicine.  

Westerners are now more openly turning to indigenous practices of healing and ritual in response to dissatisfaction with the biomedical model. Eisenberg et al. (1993) conducted a national survey in 1990, determining that the use of unconventional therapy in the United States was much greater than previously reported (extrapolated results claim one out of three Americans), as well as willingness to pay for uninsured treatments (three-quarters of the associated costs of unconventional care was paid for out-of-pocket). Researchers have found that patients usually opt for a complement of biomedical and unconventional treatment, and often seek unconventional treatment as a form of health.
promotion rather than in response to an illness (Adler, 2002; Eisenberg et al., 1993; McGuire, 1988; Pizzorno, 2002). In the United States, over the last decade, a new and growing subculture of health care practitioners, including “western” or biomedically-trained medical doctors, is seeking out training to practice shamanic healing techniques (often via U.S.-based organizations with directives to teach and preserve shamanic healing practices). The phenomenon of westerners attempting to practice forms of shamanic healing and ritual is referred to as “neo-shamanism.”

Clearly the divide between biomedicine and indigenous medicine is significant. While biomedicine tends to center on addressing the organic symptoms of an individual patient, traditional shamanism for each practicing culture is steeped in locale, kinship groupings, spirits of the place, and its communal context (Fridman, 1998:18 and 25). In this context, the role of the healing shaman is to bring the individual into balance with the community and the other-than-human world (Abram, 1996; Eliade, 1964; Reichel-Dolmatoff, 1976). Neo-shamanism is emerging in a different setting, a different cultural context than the more traditionally-deemed shamanism, and thus invariably will present itself in new and evolving ways.

**Significance**

An anthropological investigation of this emerging form of complementary health care provides a means through which to examine the syncretism of diverse systems of knowledge. Within the field of anthropology, this research will contribute specifically to the subdisciplines of critical medical anthropology, environmental anthropology, psychological anthropology, and applied anthropology. The study will provide insight into cultural shifts occurring in the United States as signified by an increased affinity for “shamanic healing,” as well as the notion of “reverse technology transfer” in which the dominant culture is looking to historically oppressed cultures for more sustainable practices in the areas of human and environmental health.

This study also will investigate more practical concerns relevant to issues of health care in the United States. Clearly, alternative health care in the United States is a poignant topic, both from an individual as well as societal standpoint. As the demand for more alternative forms of healing rise and health care practitioners gain training in these alternative modalities, the provision of medical care in the United States is metamorphosing. Even health insurance companies are changing their coverage policies to include more alternative treatment, including shamanic healing.

The adoption of shamanic healing by western medicine will also have an impact on indigenous source communities. What might those impacts be, and how does the appropriation of shamanic knowledge play out in the scheme of local identity and global transference? An anthropological investigation of this movement in the United States will serve to highlight a hybrid system of healing that illuminates the cultural implications in health care choices, and changing notions of illness and well-being, while addressing indigenous rights and the cultural survival of the oldest traditional healing practice in existence.
Methodology

The investigator has initiated the data collection process and made contact with potential research sites. Research data will be collected through surveys and questionnaires, interviews, and ethnographic participant/observation. Survey respondents and interviewees will consist of the following groups: 1) biomedically-trained health care practitioners; 2) shamanic practitioners working in an institutional health care setting; 3) clients who have received a complement of health care treatment including shamanic healing; 4) proclaimed shamans (indigenous and indigenous-trained); and 5) trainers/heads of relevant shamanism-focused organizations. Ethnographic research will be conducted at an integrative medicine health care clinic where biomedical health care and shamanic healing services are both offered.

Dissertation Committee Members:

- R. Brooke Thomas, Ph.D., Dept. of Anthropology, UMass Amherst
- David Samuels, Ph.D., Dept. of Anthropology, UMass Amherst
- Cecile Carson, M.D. University of Rochester School of Medicine
APPENDIX F

TRUE NORTH ETHNOGRAPHIC RESEARCH AGREEMENT

True North
a healthier model of healthcare
MAINE’S CENTER FOR FUNCTIONAL MEDICINE AND THE HEALING ARTS

31 October 2005

Lori Thayer
Department of Anthropology
Machmer Hall
University of Massachusetts
Amherst MA 01003-9278

Dear Ms. Thayer:

This letter is to confirm that the True North Research Circle met on 17 October 2005 to review your proposal for a research project involving True North staff, practitioners, and patients/clients. It was our consensus that this project is consistent with the mission and goals of True North, and we look forward to this project and to working with you.

I’ll ask you to meet with me to discuss the guidelines for HIPAA compliance during your time with us, and to sign a statement attesting to your understanding of our policies. Please be in touch so that we may set a time.

In the meantime, I will consult our Circle with regard to having you attend Circle meetings, in addition to conducting staff/practitioner interviews and administering the paper survey to patients.

Very truly yours,

Susan Fekety MSN CNM

cc.  Dr. Semmes (Director of Research)
     Allie Knowlton and Evelyn Rysdyk, Shamanic Practitioners

202 U.S. Route One, Falmouth, ME 04105 • (207) 781-4488 • Fax (207) 781-4470 • www.truenorthhealthcenter.org
CONFIDENTIALITY AGREEMENT

This agreement is between Lori Thayer ("Student") and the Hygeia Foundation ("Center").

Both the Student and the Center agree to the following terms and conditions, all of which are effective as of 1/15/06:

Student recognizes and acknowledges that the Center possesses certain confidential information that constitutes a valuable, special and unique asset. As used herein, the term "confidential information" includes all information and materials belonging to, used by or in the possession of the Center relating to its products, processes, methods of operation, services, programs, technology, inventions, contracts, financial information, business strategies, pricing, patients, donors, marketing plans and trade secrets of every kind and character, but shall not include (a) information that was already within the public domain at the time the information is acquired by Student or (b) information that subsequently becomes public through no act or omission of Student. Student agrees that all of the confidential information is and shall continue to be the exclusive property of the Center. Student agrees that Student shall not, at any time following the execution of this Agreement, use for other than Center purposes or disclose in any manner any confidential or other information of the Center without prior written consent of the Center.

Student and Center agree that clinical records of patients and any other records containing individually identifiable information with respect to patients shall be regarded as confidential and each party shall comply with all applicable federal and state laws and regulations regarding such records.

Except as otherwise provided herein, all other terms and conditions of agreements written or verbal between Student and Center remain in full force and effect.

AGREED

Center

[Signature]

Thomas H. Dahlberg
Executive Director

Date: 2/23/06

Student

[Signature]

Lori Thayer

Date: Feb. 13, 2006

254
December 7, 2005

Dear True North practitioners and staff,

I am an anthropologist investigating the adoption of shamanic healing practices into western medicine. As many of you know, you are participating in a unique cultural model of health care services at True North. From a cultural perspective, I am interested in learning more about your experiences and motivations, your goals, your accomplishments, and your struggles in this new effort to provide a holistic approach to health care that includes shamanic healing.

If you can spare about an hour of your time, I would appreciate the opportunity to interview you one on one at your convenience. The information gathered is to be used for my dissertation research. All information you provide will be kept confidential. Your name will not be used in connection with any publication related to this study, unless explicit permission is granted by you. An informed consent form will be provided for your signature to clarify the agreement of confidentiality as required by the Human Subjects Review Board.

Some of the ongoing changes in our culture related to shamanic practices, both within and outside the practice of health care, are very exciting. I hope you will help me explore this ongoing phenomenon. If you have any questions or concerns, please do not hesitate to contact me. I can be reached most easily by email at: thayer@anthro.umass.edu; or you can talk to me in person when I’m visiting True North.

Attached is an interview sign-up sheet. Thank you for your consideration and I look forward to meeting you.

Sincerely,

Lori Thayer
Interview Sign-Up Sheet
True North Practitioners and Staff

Please note your name, how to best reach you, what days and times you might be available to meet for about an hour, and meeting place of convenience. If you would like me to meet you some other place than True North, I am glad to try to accommodate another location that is more convenient for you.

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APPENDIX H

INTERVIEW QUESTIONS FOR TRUE NORTH PRACTITIONERS AND STAFF

Interview Questions for True North Practitioners
Interviewer: Lori Thayer, Department of Anthropology, UMass Amherst

1. What is your medical background?

2. What is your practice at True North and how long have you worked there?

3. Why did you choose to work at True North?

4. What has been your experience with True North’s unique form of decision-making and client evaluation through circles?

5. What is your definition/concept of shamanism and shamanic healing?

6. How have you integrated shamanic healing services into your treatment of clients?

7. How do you think your clients have benefitted from such complementary medical treatment?

8. Have you experienced any difficulties or problems with the practice of such complementary treatment?

9. Has the exposure to shamanic healing affected you professionally or personally in any way?

10. If you also practice elsewhere (e.g., another clinic or hospital), what has been your experience in going back and forth between two different models of health services? Does your other workplace(s) offer complementary medicine? Shamanic healing?
APPENDIX I

TRUE NORTH CLIENT SURVEY

The survey below is being administered by Lori Thayer, lead investigator of the study, and a doctoral candidate in anthropology at the University of Massachusetts at Amherst. The survey is being conducted to research the integration of shamanic healing into medical services provided in the United States. This research has been approved by the True North Research Circle.

The survey is completely voluntary and you may fill out the survey anonymously. Surveys will be kept confidential (to be read solely by the lead investigator) and any reported responses will be kept anonymous. This project does not involve the investigator’s access to a patient’s/client’s medical records.

1. Why did you choose True North as a provider of health care (i.e. what attracted you to the center?). Please check all responses that apply.

   a. ___ saw an ad/flyer/brochure
   b. ___ referred by a friend
   c. ___ referred by another health practitioner
   d. ___ wanted to see a particular practitioner at True North
   e. ___ interested/curious about complementary medicine
   f. ___ interested in receiving shamanic healing
   g. ___ other (please describe): ________________________

2. At the time that you chose to seek medical care at True North, were you aware that the health center offered the service of shamanic healing?

   • If so, were you initially interested in experiencing this form of healing?

   ________________________________________________________________

   • Have you experienced some form of shamanic healing previously?

   ________________________________________________________________

   • If you were not initially seeking shamanic healing, what made you decide to do so?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
3. How many shamanic healing sessions have you received at True North? _________

4. What other care did you receive as part of your overall treatment at True North?
   a. ___ internist/family medicine/primary care
   b. ___ gynecological/obstetrics
   c. ___ psychiatric counseling/psychotherapy
   d. ___ acupuncture
   e. ___ body work such as Reiki, Rubenfeld Synergy, Healing Touch, cranial-sacral, massage
   f. ___ other (please describe): ______________________________

5. On a scale of 1-5, with 5 being the highest, how greatly do you feel the shamanic healing session(s) has helped you?
   ___ 1 (not at all helpful)
   ___ 2 (slightly helpful)
   ___ 3 (moderately helpful)
   ___ 4 (very helpful)
   ___ 5 (incredibly helpful)

6. Would you pursue shamanic healing for other physical or emotional conditions in the future? Why or why not?
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
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7. Would you be willing to be interviewed by telephone or in person by the lead investigator of this study? If so, please provide your name and contact information below:
   Name _________________________________
   Preferred contact information (e.g. address, telephone number, email address)
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Thank you for your participation!

Please fold and mail in the attached self-addressed, stamped envelope.
APPENDIX J

INTERVIEW QUESTIONS FOR TRUE NORTH CLIENTS

Interviewer: Lori Thayer, Department of Anthropology, UMass Amherst

1. When did you first start seeing a practitioner at True North and what first led you to see the practitioner?

2. For those who saw another practitioner before seeing Allie and Evie for a shamanic healing session: When and why were you referred to see Allie and Evie?

2a. For those who first came to True North to see Allie and Evie: Did you see any other practitioners at True North? How and why were you referred to them?

3. Have you ever had a shamanic healing before? Or studied shamanism? If so, please describe.

4. How many shamanic healings have you had at True North?

5. Please describe your shamanic healing experience.

6. Compared to other shamanic healing experiences, what was the experience like to be working with two healers simultaneously?

7. Did you find the combination of shamanic healing and other treatments at True North supported each other in your healing process? Please describe.

8. Did you encounter any problems or difficulty with receiving a shamanic healing or combining it with other treatments?

9. Did you share your shamanic healing experience(s) with any family or friends? What was their response to your seeking out this kind of healing modality?

10. Will you continue to seek out shamanic healing? Would you consider it for other health problems that might arise in the future?
May 26, 2006

Dear Members of True North,

My time collecting data at True North has come to an end. I want to thank you all for allowing me to sit in circle with you. It’s truly been a wonderful experience. And also thank you for sharing your time with me for an interview. I’ve attached a copy of your Informed Consent Form.

I also want to mention to the clinicians that if any patient collaborations with Allie and Evie develop and you’re willing to share aspects of the account (honoring patient anonymity of course), I would still be interested in hearing about them. It will certainly take me awhile to write up my research, so in the coming months, please feel free to email me if you have more to share.

Although I won’t miss my many trips to the gas pump, I’ll definitely miss visiting True North. I wish you all well in your continued efforts to change healthcare in America.

Best regards,

[Signature]
APPENDIX L

TRUE NORTH PHOTOGRAPHS

Figure 1: True North Area #1

Figure 2: True North Area #2
Figure 3: True North Facade #1

Figure 4: True North Facade #2
Figure 5: True North Entrance #1

Figure 6: True North Entrance #2
Figure 7: True North Entrance #3
APPENDIX M

SOCIETY FOR SHAMANIC PRACTITIONERS (SSP) MISSION AND VISION;
AND PRINCIPLES OF INTEGRITY

SOCIETY FOR
SHAMANIC PRACTITIONERS

MISSION

We are an alliance of people deeply committed to the re-emergence of shamanic practices that promote healthy individuals and viable communities.

VISION STATEMENT

To keep up with the changing times, the Society of Shamanic Practitioners:

- Creates an alliance of diverse shamanic practitioners, which functions as a circle of peers
- Gathers and disseminates knowledge about shamanic practice
- Promotes the importance of personal responsibility in doing the inner work necessary to live and practice with integrity
- Focuses resources and shamanic energies to bring healing and unity to the world
- Provides a forum for sharing ideas about integrating shamanic practice into contemporary society, clinical practice, institutions, and efforts to heal the earth
- Encourages a dynamic exchange around how people use spiritual practice in their personal daily lives and how we bring shamanic practices into our professions
- Creates grass roots communities that support each other
- Supports education through conferences, regional gatherings and small focused retreats
- Maintains a repository of stories and clinical case studies of successful shamanic interventions
- Facilitates research evaluating the outcomes of shamanic healing
SOCIETY OF SHAMANIC PRACTITIONERS
PRINCIPLES OF INTEGRITY

To help individual practitioners be effective in service and healing in the world, and to help shift global consciousness, the Society of Shamanic Practitioners believes the following pledges represent the core principles of integrity in this pursuit:

1. I pledge to work in sacred alliance with Spirit, and to be informed and guided by that Source, and not my own ego, in offering service to others.

2. I pledge to recognize the wholeness inherent in every person or group or circumstance that comes for healing and to honor whatever form in which its pain is presented to me.

3. I pledge to be mindful of speech, thought, and action and their impact on building relationships both in the present and through time into future and past.

4. I pledge to be respectful of others, even in their differences.

5. I pledge to work with compassion and non-judgment.

6. I pledge to do no harm and to avoid any sexual misconduct in my work with clients.

7. I pledge to maintain clients’ privacy.

8. I pledge to be honest with clients and other practitioners, and to be truthful in the manner in which I present myself in public relations and advertising.

9. I pledge to offer fair and appropriate fees.

10. In service to others, I pledge to keep my own life and personhood in balance to the best of my ability.
APPENDIX N

TRUE NORTH SHAMANIC HEALERS

Figure 10: Allie Knowlton and Evie Rysdyk
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Chesworth, Jennifer, ed.

Cohen, Michael H. and David M. Eisenberg

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