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Chapter 1 : Staging an Intervention | Everyday Health

*Everyday spirit and medical interventions: Ethnographic and historical notes on therapeutic conventions in Zanzibar Town (Transactions of the Finnish Anthropological Society, 43) [Tapio Nisula] on racedaydvl.com *FREE* shipping on qualifying offers.*

This article has been cited by other articles in PMC. Many studies have explored stress and quality of life in QOL patients with cancer, under several phases of disease and treatment. However, the impact of medical intervention on psychological parameters, such as stress and quality of life focusing on psychological intervention has been sparsely studied. The main aim of the study was to examine the impact of medical intervention on the level of stress and quality of life of patients with lung, breast, and head and neck cancers. The study was carried out in hospital settings by following a one-group pre-test-post-test pre-experimental design. The effect of medical intervention was medium in case of reduction of overall stress in participants. So far as the components are concerned, the effect was high in case of psychosomatic complaints, medium in case of fear and information deficit, and low in case of everyday life restrictions. The effect of medical intervention in respect of the quality of life was found to be high in case of symptom scale pain and additional symptoms constipation ; medium in case of functional scale emotional functioning, cognitive functioning and symptoms scale nausea, vomiting. In additional symptoms scale the effect of medical intervention was found to be medium in dyspnoea and appetite loss. The findings revealed that though the medical intervention reduced stress and improved the quality of life, it was not instrumental in bringing down the stress to minimal level and enhancing the quality of life to optimum level. Therefore, the findings point to the need of inclusion of psychological intervention along with the medical intervention for minimizing stress and optimizing the quality of life of patients with cancer. People who live with cancer have a greater risk of developing various psychological problems. Studies show that cancer patients suffer not only from physical symptoms but also from the psychological and social stress associated with both diagnosis and treatment of their disease. Unfortunately, psychological distress may remain unrecognized in certain cancer patients. Patients either do not communicate their feelings or they may be unaware of their distress. Studies show that apart from the fear of dying, patients feel threatened by interventions, like chemo- or radio-therapy, and they worry about losing their bodily integrity, independence, and social roles. Thus studies show that assessment of quality of life of a cancer sufferer remains a neglected area. While these resulted in increasing survival rates, invasive therapies have also led to adverse psychological impact. While studies as above show the impact of the disease as well as the treatment on the psychological variables like level of stress as well as QOL, there needs to be an integrative psychological intervention that handles the psychological aspects alongside the necessary medical treatment that deals with the disease. Research indicates a definite positive impact on treatment outcomes when an integrative approach that focuses on stress, symptom control and quality of life is provided along with the standard therapeutic regimens. It was hypothesized that there would be an effect of medical intervention in reducing the level of stress and enhancing the QOL of these patients. The time gap between pre and post intervention psychological assessment was 6 weeks during which the participants were under three types of combined medical intervention, such as chemotherapy, radiation-hormonal therapy, and surgery. Participants Participants of the study consisted of patients 50 male, 55 female with three types of cancer viz. The sample comprised of 35 female patients with breast cancer, 35 female 8, male 27 patients with lung cancer and 35 patients female 12, male 23 with head and neck cancer. Their age group was between years of age with mean age of 52 years. Written informed consent forms were given to the patients with cancer and their consent was obtained. Only those patients who were willing to participate for the whole period of 6 weeks of study were included. Inclusion criteria also included newly diagnosed male and female patients with lung cancer, breast cancer, head and neck cancer between the age of 25â€”65 years, having no psychiatric illness irrespective of their occupation, place of living and socio economic status. Patients below the age of 25 years and above 65 years, and those having psychiatric illnesses and other physical illness were excluded from the study. There are five domains of QSC-R23, such as psychosomatic complaints, fears, information deficits,

everyday life restrictions, and social strains. Scoring was done based on the instruction manual, which indicated that higher the scores higher was the stress. The scoring was done as per the procedure standard. Procedure For conducting the study three cancer hospitals were identified and permission was taken to conduct the study. Initially senior consultants and doctors were approached to identify the patients newly diagnosed with three types of cancer under study. Such patients were included in the study after due permissions from the respective hospitals. Each identified patient was individually contacted and explained about the study. Those who consented to participate in the study were finally selected for the psychological assessment. Each of the selected participants was administered the research tools individually prior to the starting of medical intervention. During this psychological assessment, the doubts raised by the participants were clarified. However, three versions of the research toolsâ€"English, Hindi, and Teluguâ€"were used as per the requirement of the participants. The QSC-R23 was translated into Hindi and Telugu with the help of two experts, who were proficient with the respective languages as well as English. The translated versions were again re-translated into English following the same procedure with another two experts, and matched with the original English version to check the item construction and validity of each of the items. The psychometric properties had been verified through pilot study. After the initial assessment, individually tailored medical intervention was followed under the supervision of a senior medical oncologist. Reassessment with the above research tools was done after the completion of 6-week period of medical intervention. After the post assessment the participants were debriefed individually. An observation record was used for procedures used during medical intervention for a period of 6 weeks. From Table 1 , it is evident that the psychosomatic complaints scores, fears scores and information deficit scores of the patients significantly decreased after medical intervention whereas the reverse trend was noticed in case of life restrictions scores. The significant mean differences are shown in the form of bar graph in Figure 1.

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Additionally, it is this research's goal to also offer actual therapeutic interventions and guidelines that focus on spirituality and can be utilized in the counseling relationship as a way to enhance the patient's overall medical healthcare experience.

Shared decision making is a good thing. Here is how the authors of an updated Cochrane Review on Interventions for increasing the use of shared decision making SDM by healthcare professionals put the argument: SDM is a human right. This is an absolute statement. Our bodies belong to us: Any decision about them to needs to have our informed consent. Patients in general want more information about their health condition. This is a less absolute statement, and rightly so. This applies to diagnosis as well as treatment options. Patients prefer to take an active role in decisions about their health. This may or may not be true of each individual and each decision. Shared decision making does not imply that every consultation must consist of throwing information at the patient in order to end with a definitive joint answer. Examples of these activities are training programs, giving out leaflets, or email reminders. Cochrane researchers collected and analyzed all relevant studies to answer this question, and found 87 studies. The reviewers include several of the most prominent and long-standing advocates of SDM, and they must have been sad to reach this conclusion at the end of their efforts: Certainly with lots of questions and few answers, which is deeply frustrating at a time when SDM is being increasingly advocated as a fundamental principle in all health systems. In fact this Cochrane Review can be seen more as a reflection of the muddled state of research in the field than of failure to progress. The broader social movement for greater patient autonomy and open health knowledge is unstoppable, and what we see here is an attempt to capture the small part of it that gets published in the medical literature in the form of interventional trials. This is valuable, but as much for proving the limits of the Cochrane method of systematic reviewing if I may dare say that in a Cochrane blog as for the downbeat conclusion it reaches about the quality of the evidence. Complex culture change cannot be adequately measured by looking at simplistic interventions with inadequate outcome metrics. Shared decision making needs more than just knowledge Cochrane Reviews play a great role in the generation of evidence about medical interventions, and they often form the best knowledge foundation for shared decision making in clinical practice. But knowledge is just one element of SDM. For clinicians to share decisions effectively, they also need a different attitude towards their role, they need a new set of skills, they need better and more adaptable tools, and they need to be provided with the structures and the environment where real personal communication and sharing become possible. If we really believe that shared decision making is a human right, and not some unreachable Platonic ideal, we need to teach it in schools, embody it in shared knowledge tools for patients and clinicians, make it a skill for lifelong learning, and design our health system to promote it. All these things are beginning to happen. Interventions for increasing the use of shared decision making by healthcare professionals.

Chapter 3 : Impact of Medical Intervention on Stress and Quality of Life in Patients with Cancer

Everyday Spirits and Medical Interventions: Ethnographic and Historical Notes on Therapeutic Conventions in Zanzibar Town. Tapio Nisula. Saarijanjarvi: Transactions of the Finnish Anthropological Society 43, pp.

You might also like these other newsletters: Please enter a valid email address Sign up Oops! Please enter a valid email address Oops! Please select a newsletter We respect your privacy. For people coping with an alcohol or drug addiction , an intervention staged by loved ones can be the first step toward getting the necessary help. An intervention is designed to address the drug or alcohol problem and to help addicts understand that their problem needs to be addressed with proper treatment. If you are concerned that someone you care for has a problem with alcohol or drug use, you might want to consider an intervention. You can begin by starting a more informal, one-on-one conversation with your loved one about the problem. Alcohol and Drug Addiction: Seek help from a professional. This professional can help you decide whether you should stage an intervention, how to go about it, and if you do, will likely attend the intervention to help guide you through it. For formal interventions, you will need to assemble a group of people who are important to your loved one and have been affected by the alcohol or drug addiction. This group may include family, friends, medical team members, colleagues, and spiritual advisors. Practice what you will say. An intervention should focus on your care and love for the addict, and how his or her alcohol or drug addiction is affecting the individuals who are staging the intervention. Plan what you are going to say in advance, and rehearse the intervention with the group at least once in advance. During the intervention, setting limits will help your loved one understand that there will be consequences if he or she refuses to get help. Before the intervention, research and schedule treatment at an appropriate facility and determine whether insurance will cover the costs of the treatment. If your loved one agrees to go to treatment, make sure that you are able to get him or her to the treatment facility immediately. Start the intervention when your loved one is under the influence. Involve too many people. A group of three to six people who are close to your loved one is ideal. Children should not be involved in the intervention. Using words like "alcoholic" or "addict" could upset your loved one and derail your efforts. Stage an intervention when you are upset. An intervention should not be staged in the heat of an argument or when you are deeply upset. Plan ahead, stay calm, and stick to what you prepared when conducting an intervention. An intervention can be life-altering for addicts â€” most people who enter treatment for alcohol or drug addiction are prompted to do so because of pressure from their friends or family. There are several resources that can help you with staging an intervention, including the National Council on Alcoholism and Drug Dependence National Intervention Network and the Intervention Resource Center.

Chapter 4 : Shared Decision Making: essential but hard to measure - Evidently Cochrane

Everyday Spirits and Medical Interventions: Ethnographic and Historical Notes on Therapeutic Conventions in Zanzibar Town. Tapio Nisula. Saarijarvi: Transactions of the Finnish Anthropological Society, pp., appendix, bibliography, glossary.

April Article Write Us Religious and spiritual beliefs and practices are important in the lives of many patients, yet medical students, residents and physicians are often uncertain about whether, when, or how, to address spiritual or religious issues. Physicians in previous times were trained to diagnose and treat disease and had little or no training in how to relate to the spiritual side of the patient. In addition, professional ethics requires physicians to not impinge their beliefs on patients who are particularly vulnerable when seeking health care. No physician could be expected to understand the beliefs and practices of so many differing faith communities. At first glance, the simplest solution suggests that physicians avoid religious or spiritual content in the doctor-patient interaction. As with many issues, however, the simple solution may not be the best. Research indicates that the religious beliefs and spiritual practices of patients are powerful factors for many in coping with serious illnesses and in making ethical choices about their treatment options and in decisions about end-of-life care Puchalski, ; McCormick et al. This article inquires into the possibility that within the boundaries of medical ethics and empowered with sensitive listening skills, physicians-in-training and physicians-in-practice may find ways to engage the spiritual beliefs of patients in the healing process, and come to a clearer understanding of ways in which their own belief systems can be accounted for in transactions with patients. Research shows that religion and spirituality are associated positively with better health and psychological wellbeing Puchalski, ; Koenig, ; Pargament et al. How pervasive is religiosity in the United States? Religious belief and practice is pervasive in this country, although less pervasive within the medical profession. In , approximately These surveys remind us that there is a high incidence of belief in God in the US public. It also appears that physicians as a group are somewhat less inclined to believe in God. Clearly, physicians are not inquiring about spirituality to nearly the degree that patients prefer Puchalski, ; King et al. Why is it important to attend to spirituality in medicine? Religion and spiritual beliefs play an important role for many patients. When illness threatens the health, and possibly the life of an individual, that person is likely to come to the physician with both physical symptoms and spiritual issues in mind. Religion is generally understood as a set of beliefs, rituals and practices, usually embodied within an institution or an organization. Persons may hold powerful spiritual beliefs, and may or may not be active in any institutional religion. Many physicians and nurses have intuitive and anecdotal impressions that the beliefs and religious practices of patients have a profound effect upon their existential experiences with illness and the threat of dying. Recent research supports this notion. When patients face a terminal illness, religious and spiritual factors often figure into their coping strategies and influence important decisions such as the employment of advance directives, the living will and the Durable Power of Attorney for Health Care. Considerations of the meaning, purpose and value of human life are used to make choices about the desirability of CPR and aggressive life-support, or whether and when to forego life support and accept death as appropriate and natural under the circumstances Puchalski et al. He identifies specific forms of religious struggle that are predictive of mortality. A study of religious coping in patients undergoing autologous stem cell transplants also suggests that religious struggle may contribute to adverse changes in health outcomes for transplant patients Sherman et al. Referral of these patients to the chaplain, or appropriate clergy, to help them work through these issues may ultimately improve clinical outcomes Pargament, et al. How should I take a "spiritual history"? Medical students are usually introduced to the concept of spiritual inquiry in courses such as "Introduction to Clinical Medicine. Students-in-training are often hesitant to ask questions that they regard as intrusive into the personal life of the patient until they understand there are valid reasons for asking about sexual practices, alcohol, the use of tobacco, guns, or non-prescription drugs. Religious belief and practice often fall into that "personal" category that students-in-training sometimes avoid, yet when valid reasons are offered by teachers and mentors for obtaining a spiritual history, students readily learn to incorporate this line of questioning into the

patient interview. Often, the spiritual history can be incorporated into what we may now want to call the "bio-psycho-social-spiritual" patient history. Students are taught to make a transition by simply stating something like the following: If you are comfortable discussing this with me, I would like to hear from you of any beliefs or practices that you would want me to know about as your care giver. If the patient says "no" or "none" it is a clear signal to move on to the next topic, although it is often productive to ask before leaving this topic if other family members have spiritual beliefs or practices in order to better understand the family context and anticipate concerns of the immediate family. One patient-family described gratitude for their church community who brought meals to their home in a period when one parent was at work and the other was at the hospital with a sick child, leaving no one to cook for the other siblings. Others spoke of a visit from a priest, a rabbi, or a minister during their hospitalization as a major source of comfort and reassurance. One patient, self-described as a "non-church-goer," described his initial surprise at a visit from the hospital chaplain which turned into gratitude as he found in the chaplain a skilled listener with a deep sense of caring to whom he could pour out his feelings about being sick, away from home, separated from his family, frightened by the prospect of invasive diagnostic procedures and the possibility of a painful treatment regimen. Some find it helpful to have a clear approach or structure in mind when opening a discussion on spirituality with a patient or taking a spiritual history. A group at Brown University School of Medicine has developed a teaching tool to help begin the process of incorporating a spiritual assessment into the patient interview which they call the HOPE questions: Sources of hope, meaning, comfort, strength, peace, love and connection. Personal spirituality and practices E: When things are tough, what keeps you going? P Are there spiritual practices or beliefs that are important to you personally? E Are there ways that your personal beliefs affect your health care choices or might provide guidance as we discuss decisions about your care near the end of your life? How can respect for persons involve a spiritual perspective? The principle of respect for persons undergirds our duties as health care professionals to treat all persons fairly, to safeguard the autonomy of patients, and to limit the risks of harm by calculating the burdens and benefits of the care plan. Likewise, it is reinforced in religious hospitals whose mission is to care for persons as "children of God," regardless of socio-economic standing. Such caring implies care for the whole person, physically, emotionally, socially and spiritually. How should I work with hospital chaplains? It is heartening to know that the physician is not alone in relating to the spiritual needs of the patient, but can enjoy the team work of well trained hospital chaplains who are prepared to help when the spiritual needs of the patient are outside the competence of the physician. Board Certification Objective Requirements: Stephen King, personal communication, Need date Chaplains play an important role in a team approach to caring for patients. The onset of serious illness or accident often induces spiritual reflection as patients wonder, "what is the meaning of my life now? Practical questions concerning the permissibility of procedures such as an autopsy, in vitro fertilization, pregnancy termination, blood transfusion, organ donation, the removal of life supports such as ventilators, dialysis, or artificially administered nutrition and hydration, or employment of the Death with Dignity Act, arise regularly for persons of faith. In many cases, the chaplain will have specialized knowledge of how medical procedures are viewed by various religious bodies. The chaplain is also prepared to respond to patients experiencing religious struggle through expert listening and communication skills. The chaplain is a helpful resource in providing or arranging for rituals that are important to patients under particular circumstances. Some patients may wish to hear the assurances of Scripture, others may want the chaplain to lead them in prayer, and still others may wish for the sacraments of communion, baptism, anointing, formerly, the last rites , depending upon their faith system. In one case, a surgeon called for the chaplain to consult with a patient who was inexplicably refusing a life-saving surgical procedure. The conference with the chaplain opened the door for this patient to accept the care plan that she had refused earlier. In another case, a neonatologist summoned the chaplain to the NICU when it became apparent that a newly born premature infant was not going to live and the parents were distraught at the notion that their baby would die without the sacrament of baptism. Sometimes, in the fast moving delivery of health care, the chaplain, by his or her job description, is the only one on the team with sufficient time to follow up on these important patient needs and concerns. What role should my personal beliefs play in the physician-patient relationship? Whether you are religious, or nonreligious, your beliefs may

affect the physician-patient relationship. Care must be taken that the religious physician who believes differently than the patient, does not impose his or her beliefs onto the patient at this vulnerable time. In both cases, the principle of respect for the patient should transcend the ideology of the physician. Our first concern is to listen to the patient. Physicians are autonomous agents who are free to hold their own beliefs and to follow their consciences. They may be atheists, agnostics, or believers. It is clear that religious beliefs are important to the lives of many physicians. Medicine is a secular vocation for some, while some physicians attest to a sense of being "called" by God to the profession of medicine. For example, the opening line from the Oath of Maimonides, a scholar of Torah and a physician incorporates this concept: In a much earlier time in the history of the world, the priest and the medicine man were one and the same in most cultures, until the development of scientific medicine led to a division between the professions. After Descartes and the French Revolution it was said that the body belongs to the physician and the soul to the priest. In our current culture of medicine, some physicians wonder whether, when and how to express themselves to patients regarding their own faith. The general consensus is that physicians should take their cues from the patient, with care not to impose their own beliefs. In one study reported in the Southern Medical Journal in , physicians from a variety of religious backgrounds reported they would be comfortable discussing their beliefs if asked about them by patients Olive, The study shows that physicians with spiritual beliefs that are important to them integrate their beliefs into their interactions with patients in a variety of ways. These interactions were more likely in the face of a serious or life-threatening illness and religious discussions did not take place with the majority of their patients ibid. Obstacles to discussing Spirituality with Patients Some physicians find a number of reasons to avoid discussions revolving around the spiritual beliefs, needs and interests of their patients. Reasons for not opening this subject include the scarcity of time in office visits, lack of familiarity with the subject matter of spirituality, or the lack of knowledge and experience with the varieties of religious expressions in our pluralistic culture. Many admit to having had no training in managing such discussions. Others are wary of violating ethical and professional boundaries by appearing to impose their views on patients. Nonreligious physicians have expressed anxiety that a religious patient may ask them to pray. In such instances, one could invite the patient to speak the prayer while the physician joins in reverent silence. On the other hand, some physicians regularly incorporate spiritual history taking into the bio-psycho-social-spiritual interview, and others find opportunities where sharing their own beliefs or praying with a particular patient in special circumstances has a unique value to that patient. These and a myriad of other questions have religious and spiritual significance for a wide spectrum of our society and deserve a sensitive dialogue with physicians who attend to patients facing these troubling issues. Often, such questions are initiated in doctor-patient discussions and may trigger a referral to the chaplain. How can we approach spirituality in medicine with physicians-in-training? The UW School of Medicine was an early leader among medical schools in addressing the topic of patient-spirituality. In an elective course, originating in Spring, , "Spirituality in Health Care," the range of topics goes beyond simply teaching spiritual history taking. Students are encouraged to practice self-care in order to remain healthy as providers for others, and to give intentional consideration to their deep values and their own spirituality as components of their spiritual well-being. The purpose of this interdisciplinary course is to provide an opportunity for interactive learning about relationships between spirituality, ethics and health care. Some of the goals of the class are as follows: To heighten student awareness of ways in which their own faith system provides resources for encounters with illness, suffering and death. To strengthen students in their commitment to relationship-centered medicine that emphasizes care of the suffering person rather than attention simply to the pathophysiology of disease, and recognizes the physician as a dynamic component of that relationship. To encourage students in developing and maintaining a program of physical, emotional and spiritual self-care, which includes attention to the purpose and meaning of their lives and work. McCormick, Until recently, there were all too few medical schools that offered formal courses in spirituality in medicine for medical students and residents.

Chapter 5 : Spirituality and Medicine: Ethical Topic in Medicine

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Etymology[edit] The earliest known depiction of a Siberian shaman, by the Dutch Nicolaes Witsen , 17th century. Witsen called him a "priest of the Devil" and drew clawed feet for the supposed demonic qualities. It is found in the memoirs of the exiled Russian churchman Avvakum. Ethnolinguist Juha Janhunen regards it as an "anachronism" and an "impossibility" that is nothing more than a "far-fetched etymology. Ethnolinguists did not develop as a discipline nor achieve contact with these communities until the late 19th century, and may have mistakenly "read backward" in time for the origin of this word. A shamaness female shaman is sometimes called a shamanka, which is not an actual indigenous term but simply shaman plus the Russian suffix -ka for feminine nouns. The English historian Ronald Hutton noted that by the dawn of the 21st century, there were four separate definitions of the term which appeared to be in use. The first of these uses the term to refer to "anybody who contacts a spirit world while in an altered state of consciousness. The third definition attempts to distinguish shamans from other magico-religious specialists who are believed to contact spirits, such as " mediums ", " witch doctors ", "spiritual healers" or "prophets," by claiming that shamans undertake some particular technique not used by the others. Problematically, scholars advocating the third view have failed to agree on what the defining technique should be. The fourth definition identified by Hutton uses "shamanism" to refer to the indigenous religions of Siberia and neighboring parts of Asia. However, shamanic powers may be inherited. In traditional societies shamanic training varies in length, but generally takes years. The significant role of initiatory illnesses in the calling of a shaman can be found in the detailed case history of Chuonnasuan , who was the last master shaman among the Tungus peoples in Northeast China. This process is important to the young shaman. They undergo a type of sickness that pushes them to the brink of death. This happens for two reasons: The shaman crosses over to the underworld. This happens so the shaman can venture to its depths to bring back vital information for the sick and the tribe. The shaman must become sick to understand sickness. When the shaman overcomes their own sickness, they will hold the cure to heal all that suffer. This is the uncanny mark of the wounded healer. Most shamans have dreams or visions that convey certain messages. The shaman may have or acquire many spirit guides , who often guide and direct the shaman in their travels in the spirit world. These spirit guides are always present within the shaman, although others encounter them only when the shaman is in a trance. The spirit guide energizes the shaman, enabling them to enter the spiritual dimension. The shaman also cleanses excess negative energies, which confuse or pollute the soul. Shamans act as mediators in their culture. The shaman communicates with both living and dead to alleviate unrest, unsettled issues, and to deliver gifts to the spirits. Among the Selkups , the sea duck is a spirit animal. Ducks fly in the air and dive in the water. Thus ducks are believed to belong to both the upper world and the world below. The lower world or "world below" is the afterlife primarily associated with animals and is believed to be accessed by soul journeying through a portal in the earth. Shamans perform a variety of functions depending upon their respective cultures; [34] healing, [35] [36] leading a sacrifice , [37] preserving the tradition by storytelling and songs, [38] fortune-telling , [39] and acting as a psychopomp "guide of souls". In most languages a different term other than the one translated "shaman" is usually applied to a religious official leading sacrificial rites "priest" , or to a raconteur "sage" of traditional lore; there may be more of an overlap in functions with that of a shaman , however, in the case of an interpreter of omens or of dreams. There are distinct types of shaman who perform more specialized functions. For example, among the Nani people , a distinct kind of shaman acts as a psychopomp. These roles vary among the Nenets , Enets , and Selkup shaman. He or she accompanies the rituals and interprets the behavior of the shaman. For this interpretative assistant, it would be unwelcome to fall into trance. This system is conceptualized mythologically and symbolically by the belief that breaking hunting restrictions may cause illness. As the primary teacher of tribal symbolism, the shaman may have a leading role in this ecological management, actively restricting hunting and fishing. The shaman is able to "release" game animals, or their souls, from

their hidden abodes. In many Inuit groups, they provide services for the community and get a "due payment" cultures ,[who? Shamans live like any other member of the group, as a hunter or housewife. Due to the popularity of ayahuasca tourism in South America, there are practitioners in areas frequented by backpackers who make a living from leading ceremonies. Common beliefs identified by Eliade [5] are the following: Spirits exist and they play important roles both in individual lives and in human society. The shaman can communicate with the spirit world. Spirits can be benevolent or malevolent. The shaman can treat sickness caused by malevolent spirits. The shaman can employ trance inducing techniques to incite visionary ecstasy and go on vision quests. The shaman evokes animal images as spirit guides , omens , and message-bearers. Shamanism is based on the premise that the visible world is pervaded by invisible forces or spirits which affect the lives of the living. Commonly, a shaman "enters the body" of the patient to confront the spiritual infirmity and heals by banishing the infectious spirit. Many shamans have expert knowledge of medicinal plants native to their area, and an herbal treatment is often prescribed. In many places shamans learn directly from the plants, harnessing their effects and healing properties, after obtaining permission from the indwelling or patron spirits. In the Peruvian Amazon Basin, shamans and curanderos use medicine songs called icaros to evoke spirits. Before a spirit can be summoned it must teach the shaman its song. Such practices are presumably very ancient. Plato wrote in his Phaedrus that the "first prophecies were the words of an oak", and that those who lived at that time found it rewarding enough to "listen to an oak or a stone, so long as it was telling the truth". Other societies assert all shamans have the power to both cure and kill. Those with shamanic knowledge usually enjoy great power and prestige in the community, but they may also be regarded suspiciously or fearfully as potentially harmful to others. Shamanic plant materials can be toxic or fatal if misused. Spells are commonly used to protect against these dangers, and the use of more dangerous plants is often very highly ritualized. Soul and spirit concepts[edit] See also: Soul dualism The variety of functions described above may seem like distinct tasks, but they may be united by underlying soul and spirit concepts.

Chapter 6 : Spiritual Messages | Every Day Spirit

The HIV epidemic has had a profound impact on people's everyday life in most African societies. A large proportion of all new HIV infections involves young people between 15 and 25 years.

Chapter 7 : Stroke prevention: medical interventions for everyday practice | Medicine Today

Based on ethnographic fieldwork and on archive research, NisulaÂ´s Doctoral dissertation investigates the spirit possession phenomenon in relation to biomedical practices in Zanzibar, Tanzania. This exploration of health and healing in an urban islamic context suggests that the popularity of.

Chapter 8 : Shamanism - Wikipedia

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