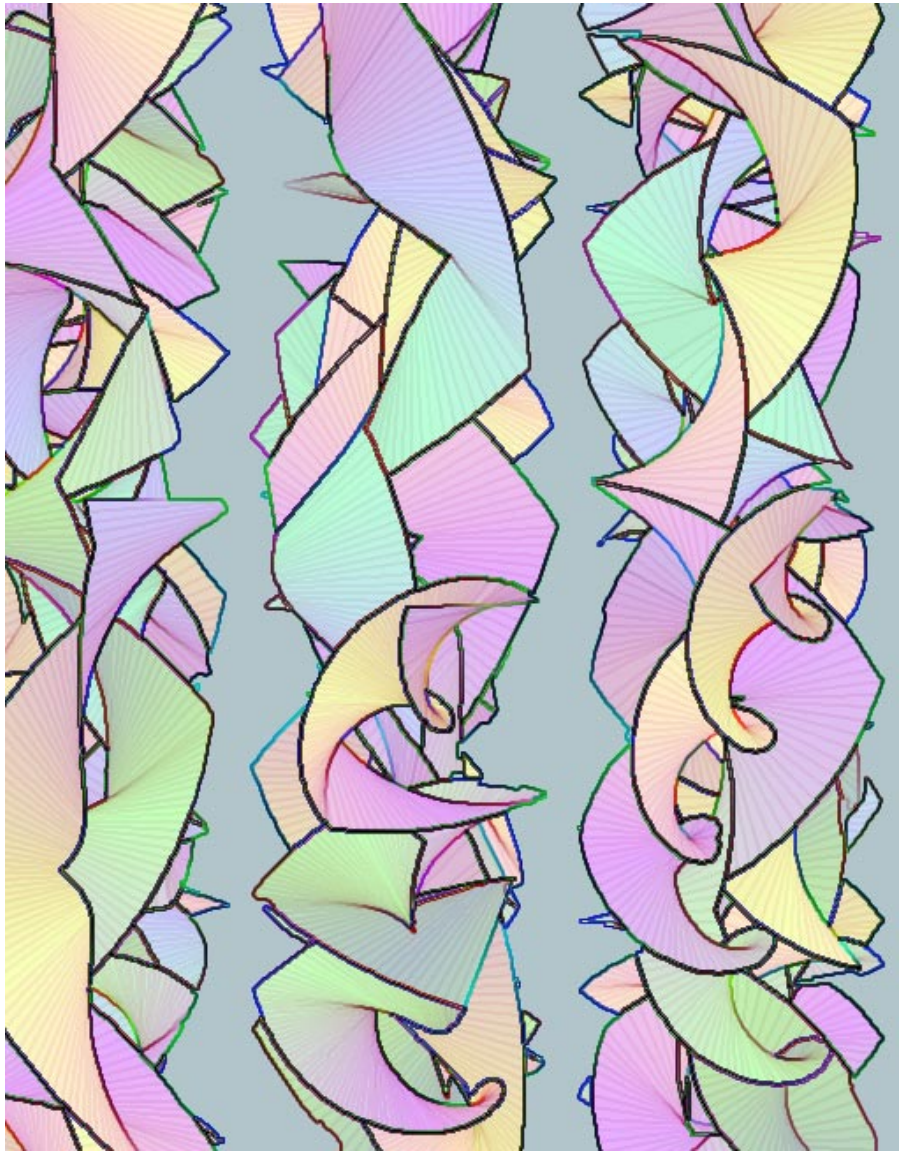

Does research evidence exist for spiritual healing

David Aldridge

Spiritual healing is described according to three main categories. One is concerned with spirituality and its implications for well being as it occurs in clinical practice. Another refers to the communal and social benefits that spiritual healing brings. A third is concerned with explanations of spiritual healing-- sometimes in this sense called "mental healing"-- based upon energetic, esoteric or parapsychological reasoning.

Prayer is seen by many cultures as an important activity in the maintenance of well-being, as a coping response in times of stress, as a healing activity and as a source of comfort. To ignore such a powerful agent, with the elderly, the dying and the chronically ill, is a folly. Removing the pillar of spirituality from our culture is absurd as removing the pillar of science.

Illness may be seen as a step on life's way that brings us in contact with who we really are. The positive aspect of suffering has been neglected in our modern scientific culture such that we, as practitioners and patients, search for immediate relief. This is not to advocate suffering, rather to we do not lose the potential of suffering for transformation of the individual. To accept the teaching of suffering, while pursuing relief from that suffering and comforting the sick, would also restore the doctor to the status of teacher for the patient.

Introduction:

The natural science base of modern medicine, which in turn influences the way in which modern medicine is delivered, often ignores the spiritual factors associated with health. Health invariably becomes defined in anatomical or physiological, psychological or social terms. Rarely do we find diagnoses that include the relationship between the patient and their God. The descriptions we invoke have implications for the treatment strategies we suggest, and the way in which we understand how people can be encouraged to become healthy or maintain that state that we know of as "health". Patience, grace, prayer, meditation, hope, forgiveness and fellowship are as important in many of our health initiatives as medication, hospitalisation, incarceration or surgery. The spiritual elements of experience help us to rise above the matters at hand such that in the face of suffering we can find purpose, meaning and hope (Haiti 1986).

However, spiritual healing continues to exist, renewing itself with successive generation in the face of modern scientific medicine. In a previous volume of this journal several authors (Cunningham 1992; Klivington 1992; Sloan 1992; Smith 1992) have responded to the question "Does spirit matter"? as put to them by the editor (Dienstfrey 1992). Another author in the same volume has also made the connection between ideas of spirituality and "energy" (Leskowitz 1992), ideas that play an influential role in the explanatory systems of spiritual healers as we will see later. This paper intends then to extend that argument and to offer some evidence from a variety of sources that spirituality is a viable idea within modern medical practice and worthy of debate.

Perhaps two examples will illustrate this concept as it appears in daily practice

A 59 year old woman, recently widowed, was referred to my practice after having taken an overdose of

her prescribed pain medication. At the time, as research psychologist, I was seeing all patients within a given area of South West England as part of a research project attempting to understand why people attempted suicide (Aldridge 1984; Aldridge & Rossiter 1983; Aldridge & Rossiter 1984). This woman had a history of chronic pain. A clinically significant point was reached when, after extensive tests and repeated therapeutic interventions, no organic grounds for her pain were found and her problem was declared by her specialist consultants as "psychological" in origin. She was then referred to a psychiatrist. At this point she overdosed with pain medication. During our initial conversation, after eliciting the previous history, she described her problem as "being abandoned by God". The reader can perhaps understand my embarrassment at the time as either I was faced with what appeared to be a psychiatric problem, for which I could find no grounds from the rest of her conversation, or a problem completely out of my therapeutic range. Indeed, her life was one lacking in hope, lived in isolation and perpetual suffering. Her religion made little sense to her anymore, and her priest could not comfort her. Moreover, her family doctor, and confidant, had passed her on to a psychiatrist; an act in her eyes that condemned her as mad.

This case reflects a growing problem in our current society. People are suffering, often alone. They are without hope and feel abandoned. When pain is expressed in this way, it has no simple causal reality (Morris 1992). One of the ways in which people express their suffering is by contacting a general practitioner or family doctor. When this contact fails, or they are stigmatised by the suggestion that their problem is psychiatric, then they are further alienated. Alienated in a system of organised care that is set up to protect them.

Another example. A priest contacted me on behalf of one of his parishioners. A professional man in his late thirties, married with two children, had been treated with a marrow transplant for leukaemia. There was little evidence of success. The patient was in increasing pain and his blood status was causing concern. His wife had become withdrawn. His oncologist, when asked what the next step was, had suggested that they pray. Nothing more, it appeared could be done for this patient.

Again, we have a similar situation to the first case. A man, this time with his family, is suffering. The family are faced with a loss of hope. Their plans for the future no longer have any meaning. The medical initiatives have been exhausted. In both examples the patients were asking "Why me, what have I done to deserve this?". It is with such, by no means extraordinary, examples that we are asked to practice modern medicine. I shall argue that these issues of abandonment, suffering, loss of hope and meaning, the transitions from living to dying are essentially spiritual.

What is spirituality?

Benor, an American psychiatrist now resident in England who has made a detailed study of healing initiatives (Benor 1991), offers a definition of healing which succinctly combines most of the modern concepts found in spiritual healing. Healing is "*...the intentional influence of one or more persons upon a living system without using known physical means of intervention*" (p9). Thus healing is predominantly an activity of the mind as it impinges on matter.

Hiatt (Hiatt 1986), as psychiatrist, offers an understanding of the spiritual in medicine that can also be worked with in psychologic terms. "*Spirit refers to that noncorporeal and nonmental dimension of the person that is the source of unity and meaning, and "spirituality" refers to the concepts, attitudes, and behaviours that derive from one's experience of that dimension". Spirit can be addressed only indirectly and inferentially, while spirituality can be understood and worked with in psychologic terms*". He suggests that by taking such a psychologic framework then we can discuss and use spiritual healing "within a modified western framework (of medicine)" (p742). Thus healing is predominantly an activity of the spirit upon the mind.

In recent years the word spiritual has appeared increasingly in the nursing literature (Emblen 1992; Reed 1987) where spiritual needs have been differentiated from religious needs (see Figure One). Spirituality has a broader perspective, characterised by the idea of transcendence, than religion. Religious care means helping people maintain their belief systems and worship practices. Spiritual care helps people to maintain personal relationships and relation ship to a higher authority, God or life force (as defined by that individual); identify meaning and purpose in life; and, transcend a given moment. This idea of transcendence, the ability to extend the self beyond the immediate context to achieve new perspectives, is seen as important in the last phases of life where dying patients are encouraged to maintain a sense of well-being in the face of imminent biological and social loss. We shall return to this idea of spirituality and well-being in the following sections where the health implications for dying patients and the elderly are discussed.

Figure One: Meanings of Spirituality

author	description
Emblen, J 1992	"..helping people to identify meaning and purpose in their lives, maintain personal relationships and transcend a given moment."
Kuhn,C 1988	"..those capacities that enable a human being to rise above or transcend any experience at hand. They are characterised by the capacity to seek meaning and purpose, to have faith, to love, to forgive, to pray, to meditate, to worship, and to see beyond present circumstances."
Hiatt,J 1986	"..that aspect of the person concerned with meaning and the search for absolute reality that underlies the world of the senses and the mind and, as such, is distinct from adherence to a religious system."
Smyth,P 1988	"..that life has a purpose, of the search for meaning, of the attempt to interpret their personal illness in a way that makes sense of their world view."

Generally spiritual healing is described according to three main categories. One is concerned with spirituality and its implications for well being as it occurs in clinical practice. Another refers to the communal and social

benefits which spiritual healing brings. A third is concerned with explanations of spiritual healing-- sometimes in this sense called "mental healing"-- based upon energetic, esoteric or parapsychological reasoning. I shall offer examples from each of these categories and then offer a discussion that considers the historical and social contexts of spiritual healing.

Clinical experience and well-being

At the level of daily practice general practitioners have been willing to entertain the idea of spiritual healing and incorporate it into their practice, to use spiritual explanations for some of their patient contact, or to include spiritual healers as part of their referral network (Brown & Sheldon 1989; Cohen 1989; Pietroni 1986). Cohen (1989) emphasises the value of touch, time and compassion that the healer can offer, and the benefits of referral (see Table One). Such practice points out the value of working together as a referral network of practitioners.

The demand for whole person treatment has been strenuously adopted by some nursing groups who remind us that in caring for the patient there is a need to include spiritual needs and to allow for the expression of those needs (Boutell & Bozett 1990; Burkhardt 1989 May; Clark et al. 1991; Grasser & Craft 1984; Labun 1988 May; Soeken & Carson 1987; Stuart, Deckro, & Mandle 1989). Within these approaches there is a core of opinion that accepts that suffering and pain are part of a larger life experience, and that they can have meaning for the patient, and for the carer(s) (Nagai Jacobson & Burkhardt 1989). The emphasis is placed upon the person's concept of God, sources of strength and hope, the significance of religious practices and rituals for the patient and their belief system (Soeken & Carson 1987). Spiritual well-being is also proposed as a hedge against suicide providing some people with a reason for living (Ellis & Smith 1991) and as a mediator of depression (Fehring, Brennan, & Keller 1987).

Table One: Response of patients and healers as general practice referrals to a London healing group *

Response	Patient	Healer
A great deal better	5	4
A good deal better	16	18
A lot better	9	10
A bit better	5	6
No different	9	6

* after (Cohen 1989)

Doctors, nurses and clergy have worked together to care for the dying (Conrad 1985; Reed 1987; Roche 1989), and a community approach, that includes the family of the patient and his or her friends, appears to be beneficial (Aldridge 1987a, 1987b,1987c,1987d) (see Figure Two). These principle benefits are concerned with a lessening of state-trait anxiety, general feelings of well being and an increasing spiritual awareness for the dying person regardless of gender, marital status, age, or diagnosis (Kaczorowski 1989). In addition, comprehensive treatment programmes for people with AIDS recommend that the spiritual welfare of the patient, and its influence on the well-being, is included (Belcher, Dettmore, & Holzemer 1989; Flaskerud & Rush 1989; Gutterman 1990; Ribble 1989).

Reed's study (1987) of spirituality and well-being in terminally ill hospitalized patients hypothesized that terminally ill patients would indicate a significantly greater spiritual perspective than non-terminally ill hospitalized adults with problems that were not typically life-

Figure Two: Family change and terminal illness *

Coping with physical changes	Anticipation of pain
	Management of pain
	Management of the physical sequelae of illness (nausea, incontinence) and change in physical appearance
	Management of the physical sequelae of treatment
Coping with personal change	Loss of hope, fitness and identity
	Anxiety and depression about the future
	Loss of role in family and in employment
	Frustration and helplessness
Coping with family and marital changes	Resolution of conflict, Change in parental roles
	Anxiety about the future welfare (emotional and financial)
	Anticipated hospital contacts and treatment
	Anticipated loss of a family member
	Planning the future
	Social isolation
	Changes in family boundary, and of family and marital emotional distance
	Negotiation of dependence/independence
	Saying 'goodbye' and talking about dying
	Handling the above personal and physical changes
	Loss of sexual activity
Coping with spiritual changes	Feelings of loss, alienation and abandonment
	Understanding suffering
	Accepting dependency
	Handling anger and frustration
	Forgiving others
	Discovering peace
	Discussing death
	Grieving
	Planning the funeral
	Discovering the value of living

It must be emphasized that these changes have ramifications through the interconnected systems. Personal changes have implications for family and community members. * (Aldridge 1987b) p214.

threatening, and healthy non-hospitalized adults. Her self-developed Spiritual Perspective Scale (Reed 1986) was used to assess the extent to which spirituality played a meaningful role in the life of the patient, based on the patients own understanding of spirituality. An Index of Well-Being (Campbell, Converse, & Rodgers 1976) was used to measure participant's satisfaction with life according to both cognitive and affective dimensions of general well-being. Both instruments had been previously examined for reliability and validity and found to be acceptable for the health groups studied. The hospitalized patients were recruited from the same hospitals.

For the terminally ill patients there was shift towards greater spirituality as indicated by a stronger faith and increased prayer. Adults who become increasingly aware of their own mortality appear to develop a greater need for the spiritual dimension of life. As the well-being scores were similar for all three groups the author hypothesizes that spirituality is a source of well-being for the terminally ill.

It is not only for the dying that spirituality plays a role. For the widow who must adapt to the loss of a partner, the ability to express her spirituality can, along with other criteria, play an important role in enhancing well-being. In a study of widows between the ages of 40 and 89 (Malatesta et al. 1988), women over 49 years old rated physical exercise, church-group activities, expressing spirituality and interacting with friends and relatives as similar in their effectiveness. For young and old groups of widows, attention to spiritual needs, physical exercise and a willingness to be self-indulgent all contributed to satisfy emotional and sexual needs.

Spirituality and religion, then, appear to be mediating factors for coping with an impending loss of life, and appear to be positive factors for maintaining well being particularly in older patients. As we shall see below, the use of prayer as spiritual practice with the elderly is an intervention to medical and nursing practitioners.

Prayer

Prayer is described by several authors as valuable in caring for the elderly across several cultures (Chatters & Taylor 1989; Garrett 1991; Gorham 1989; Koenig, Bearon, & Dayringer 1989; Markides 1983; Reed 1987; Taylor & Chatters 1991). Medical help seeking and prayer are not mutually exclusive activities, as prayer is considered by patients to be an active coping response in the face of stressful medical problems (Bearon & Koenig 1990).

A study of 160 physicians found that physicians also believe that religion has a positive effect on physical health, that religious issues should be addressed and that the older patient may ask the physician for prayer (Koenig, Bearon, & Dayringer 1989). While some physicians advocated active prayer with the patient, physicians were more likely to support more passive and less intimate forms of religious interaction and patients were more likely to mention such issues if the initiative was taken by the doctor. An influential factor for requesting prayer is the belief system of the practitioner, which may influence in turn the willingness of the patient to talk about such matters. Expressing spirituality in such encounters appears to be a deterrent for affective disorders such as depression, as a factor in promoting health-seeking behavior and a promoter of compliance with medical initiatives.

Koenig (1989) admits that spirituality is a sensitive topic in the primary care of the patient both for patient and practitioner. The older practitioner is likely to have been trained in the model that proscribes religion and personal matters in the treatment plan. Younger colleagues, perhaps aware of the biopsychosocial model, may be more willing to include psychosocial concerns.

Nevertheless, the neglect of spiritual and religious matters may have contributed to patient dissatisfaction over the depersonalization of health care. In the above study patients said that in times of great emotional and personal distress they would like their physician to pray with them and that religious faith was an important influence in their lives. In considering chronic illness and stressful life events, religious and spiritual considerations are necessary in understanding the patient as a person with a constellation of individual needs rather than a collection of symptoms. I shall return to this point later in the section on health beliefs.

Although initial clinical research into the benefits of prayer had been inconclusive (Collipp 1969; Joyce & Welldon 1965; Rosner 1975) more recent studies, from a broader medical perspective and with larger study populations, have shown that intercessory prayer is beneficial.

Table Two: Positive therapeutic effects of intercessory prayer in a coronary care unit population *

New problems and therapeutic events	Intercessory prayer group % (No.)	Control group % (No.)	p
Congestive heart failure	4(8)	10(20)	<0.03
Diuretics	3(5)	8(15)	<0.05
Cardiopulmonary arrest	2(3)	7(14)	<0.02
Pneumonia	2(3)	7(13)	<0.03
Antibiotics	2(3)	9(17)	<0.005

* taken from (Byrd 1988)

In a coronary care unit the group receiving intercessory prayer had an overall better outcome requiring less antibiotics, diuretics and intubation/ventilation than control (Byrd 1988) (Table Two).

Byrd (1988) evaluated the effects of prayer in a coronary care unit population, using a prospective randomized double blind protocol. Over ten months, 393 patients admitted to the unit were randomized, after signing informed consent, to an intercessory prayer group (192 patients) or to a control group (201 patients). While hospitalized, the first group received daily prayer from participating Christians praying outside the hospital; the control group did not. The aims of the prayers were for a rapid recovery, the prevention of complications and death and any other improvements that may be beneficial.

At entry, the groups were statistically identical. After entry, all patients had a clinical follow up for the remainder of the admission. The investigator, doctors and nursing staff remained "blind" to which group the patients were allocated throughout the study. After allocation the patients were not contacted further by the investigator to avoid any bias. Each patient in the prayer group was assigned to between three and seven intercessors - those who would pray for them (intercede with God). The people who were doing the praying new the patient's first name only, the medical diagnosis of the patient along with their general condition and were informed of any changes in condition. The group receiving prayer had a significantly lower severity score based on clinical events of the hospital course after entry. A *good* course occurred when no new diagnoses, problems or therapies were recorded. An *intermediate* course occurred if there were higher levels of morbidity and a moderate risk of death. Those with the highest morbidity risk, or who died during the study, were considered to have had a *bad* course. The control patients required ventilatory assistance, antibiotics, and

diuretics more frequently than patients in the prayer group. (Five per cent of the prayer group were considered to have had a good hospital course as compared to 73 per cent in the control group; an intermediate course was observed in 1 per cent of the prayer group and 5 per cent of the control group; and, 14 per cent of the prayer group had a bad course compared with 22 per cent of the control group.)

In a recent study by Saudia (Saudia et al. 1991), the relationship between health locus of control and helpfulness of prayer as a direct-action coping mechanism in patients before having cardiac surgery was examined. The Multidimensional Health Locus of Control Scales and the investigator-developed Helpfulness of Prayer Scale were issued to 100 subjects 1 day before cardiac surgery. Ninety-six subjects indicated that prayer was used as a coping mechanism in dealing with the stress of cardiac surgery, and 70 of these subjects gave it the highest possible rating on the Helpfulness of Prayer Scale. Prayer was perceived as a helpful, direct-action coping mechanism and warranted support by health personnel. Prayer appears to be an active coping mechanism relevant for medical practice particularly in stressful situations.

Prayer as a coping mechanism was also discovered in another patient group. Less than four years after a kidney transplant, 40 patients rated the severity of 35 potential stressors (Sutton & Murphy 1989). Patients then rated the extent to which they used each of 40 coping strategies to deal with stress. The most stressful items were cost factors and fear of kidney rejection; fear of not being accepted by family and friends was least stressful. Prayer and looking at the problem objectively were used most in coping with stress. Drug and alcohol abuse and blaming others for problems were used least. At the pragmatic level of the patient, prayer and looking at the problem objectively are considered complementary activities.

In the treatment of alcoholism there has been an historical influence of spiritual considerations being included in treatment plans (McCarthy 1984) apart from the temperance movement. Such treatments for alcohol abuse are often composite packages using physical methods of relaxation, psychological methods of suggestion and auto-suggestion, social methods of group support and service to the community, and spiritual techniques of prayer. These approaches have been extended into the realm of chemical dependency (Buxton, Smith, & Seymour 1987) and substance abuse (Prezioso 1987) treatment.

Health beliefs ands social explanations

While people claiming active membership of a religious institution in England is very low, many people report that they have had a spiritual experience at some time or another (Hay & Morisy 1985). When given the chance, people will talk about such seemingly common experiences. What is at issue here is that spirituality is not mentioned in medical dialogues as it appears not to be pertinent to the physician. However, while it may not be usual for the medical practitioner to bring the sacred into the medical consultation secular medical knowledge is found to be wanting at particular critical moments in medical consultations as suggested so far in this paper. As we have read earlier, prayer is understood by patients as an active coping mechanism. New efforts for lay involvement in medicine, and a call for spiritual (or wholistic) understandings of illness made by the nursing profession, are the expressions of individual calls for the inclusion of such meaning according to patient beliefs. For the patient it is vital to make sense of experience. It is a search for meaning in the face of stress, chaos, loss, loneliness, hopelessness and impending or current suffering.

It is at the level of health beliefs that perhaps the most acceptable conventional forms of healing explanations take place. Black American women with AIDS (Flaskerud & Rush 1989) described the sources of their illness and their remedies in two broad categories; natural and supernatural. Prevention, prayer and spirituality were included in a treatment program that incorporated traditional beliefs based on the understanding so the women themselves. This incorporation of modern and traditional has also been described in treating various ethnic groups throughout the world (Conway 1985; Dillon 1988; Durie 1985; Griffith 1983; Loudou & Frankenberg 1976; Romano 1965; Viens 1983)

What is important to learn from these experiences is that patients have concerns for the origins and meanings of symptoms that are important for them, that these meanings are mixed, and such meanings have implications for the way in which they believe they may be healed. It is as important to recognize and respect the symbolic meanings and world view of the person being treated as it is to remove a source of bacterial or viral infection (the symbols of modern medicine).

Symbolic meaning plays an active part in disease formation, the classification of diseases, the cognitive management of illness, and in therapy (Kleinman 1978; Kleinman & Sung 1979; Kleinman 1973). Symbolic meaning provides a bridge between cultural and physiological phenomena, and is the locus of power whereby illness is explained and controlled. These symbolic meanings are often contained within particular ritual practices, hence the prohibition of spiritual healers from wearing white coats in hospitals. If such healers did wear white coats there would be a confusion of symbolic realities and hierarchies belonging to particular rituals of orthodox medicine.

Griffith (Griffith & Mahy 1984) describes this cultural discrepancy in a church based healing clinic that mixed both orthodox modern medicine and spiritual healing. Not only were there differences in healing descriptions about what happened in the clinic, there were differences in rituals--laying-on-of-hands and prayer v. consultation and injections--and differences in hierarchies of practitioners. While practitioners from differing traditions may work in parallel, it is another gigantic step to ask that they work in unison. Some authors see a danger in such unity in that so-called marginal healing practices may be "medicalized" and lose some of their vitality (Glik 1988).

It is a change in the sense of meaning of life that appears to characterise many reports of healing rituals. Marginalized individuals; the sick, the poor, the lonely and the elderly, are brought into a group context where they are cared for and accepted. For some participants this offers a way of self expression and fulfilment within a communal context thereby ritually affirming the social worth of the individual (Griffith & Mahy 1984; Griffith, Mahy, & Young 1986). Thus some church based healing groups are more concerned with lifestyle approaches rather than physical pathologies. From this perspective; sickness, when placed in the hands of a divine authority, releases the patients to a new form of living and integration within a community. This is the significance of the sacrament of the laying-on-of-hands as a sacred reality (Csordas 1983)--practically placing the sickness in the hands of God--and not to be equated as some writers do with the therapeutic touch of the doctor as a secular reality.

We have seen earlier for widows that contact with others combined with the ability to express spiritual needs contributes to a feeling of well being. If we consider the plight of widows throughout the world, and the trends in suicide mortality in the elderly (Mao et al. 1990; Pinto & Koelmeyer 1991; Schmidtke & Weinacker 1991; Sverre 1991), we may wish to ponder how seemingly unconventional approaches like prayer and encouraging the social activity of belonging to a Church group would alleviate the problems of living alone, social isolation and

hopelessness. While the medical practitioner cannot be held responsible for the increase of home care and the disintegration of the social network, he or she can initiate activities for the patient that may bring her into contact with those who may stimulate her reason for living and bring her into contact with a social group who would support her. While the evidence for such a suggestion is scattered among the literature, it seems a matter of common sense reason to encourage family practitioners to try and incorporate aspects of social medicine.

Isolation cannot be treated with medication. It is a sad reflection on our medical understandings of the elderly that medication that is prescribed for the relief of their problems is the agent of their deaths. In Norway where suicide has increased in the elderly, benzodiazepine hypnotics are the toxic agents in 56% of the cases of attempted suicide (Ekeberg & Aargaard 1991). We must be aware that elderly individuals present their problems as somatic complaints to their physicians (Eisenberg 1992). These complaints must not be taken at face value, rather they should be understood as expressions of psychological and social distress. The expression of distress as sleeplessness and chronic pain can be understood in the context of isolation and loneliness. While prayer and church going are not a panacea for all ills, they would surely set the appropriate social and psychological context for the delivery of conventional medical initiatives whereby medication may be appropriate, and encourage the compliance for which those medical initiatives are dependent.

However, it is the poor, the lonely and the isolated who are prey to abuse by so-called spiritual healers. Those television healers who appeal to the public for money are often preying on the sympathies of those who have little hope, and whose sole contact with another person with a caring attitude is through television. Apart from being an indictment of our uncaring society, it is also a reminder that spiritual healing in the name of evangelism can be usurped for material purposes. In biblical times healers, as evangelists, were not allowed to receive material or monetary gain for their endeavours. They had to earn their living by means of a trade. St. Paul was a tent maker, for example. Such a coarse yardstick may be applied today; if spiritual healing costs money or is followed by a request for a donation, then treat it with suspicion. Some fundamentalist healers appear to have a selective understanding of biblical healing when it comes to caring for the needy which often appears as exploiting the poor.

Healing, energy and mental healing

We turn now to a field of explanations completely different to the previous clinical examples and psychosocial explanations that inferred no causal mechanisms.

How spiritual healing is explained, its influence demonstrated and evidence presented raises a number of problems. First, that which is of the "spirit", i.e. non-material, is not readily accessible to demonstration and explanation within the limit of a physicalist science although the effects of healing are often expected to be shown in material change. Second, the words that are used for describing differing forms of healing are based on varying traditions and have differing meanings.

Explanations given for how such spiritual healing works are sometimes paraphysical, energetic or magnetic. The principal explanatory principal is that there are divine energies that are transformed from the spiritual level by the agency of the healer and which produce a beneficial influence upon the 'energy field' of the patient. This notion of 'energy field' is the sticking point between orthodox researchers (Jacobs 1989; Wood 1989) and spiritual practitioners in that, if such a field exists then it should be possible to measure by physical means.

The problem probably lies in the use of the word 'energy', which has a broader interpretation in spiritual healing, and is likened to organising principles of vitalism and life force that bring about a harmonising of the whole person. The source of the word energy in the Greek is *ergon* meaning to work in a physical sense, and it is this meaning that is used by modern scientists. The alternative sense of the word--to be active or possessed by a demon--is more often used by spiritual healers. If we add the prefix *en*, then we have *energio* -- to be in action; in this sense *energy* is used by modern spiritual healers to suggest dynamic forces that are channelled or set in motion by the healer, or the patient.

While the state of mind necessary for healing has been elusive to research there has been quite extensive research into the physical sequelae of spiritual healing phenomena that has included investigations using controlled trials. Enzymes and body chemicals in vitro have been studied, as have the effects of healing on cells and lower organisms (including bacteria, fungus and yeasts), human tissue cells in vitro, the motility of simple organisms and plants, on animals and on human problems (Benor 1990a,1990b, 1991; Solfin 1984).

While spiritual healing is often dismissed as purely a placebo response, the evidence from studies of lower organisms and cells would indicate that there is direct influence. We must ask ourselves why would a single celled organism want to please a human--"to please" as in placebo. This way of thinking is surely an unacceptable form of anthropomorphism. Gregory Bateson has pointed out that "a dormitive principle" was used by scientists to describe the effects of morphine (Bateson 1972). Such a principle in reality did not exist, it was a pseudo-scientism adopted for the purposes of explanation. We may assume that in some cases "placebo" is invoked when in reality we should say that we do not understand what is happening. Even if we introduce the idea of "expectancy effects" as an influence on experimental data we are still left with a body of knowledge that begs understanding (Solfin 1984). In fact the explanations of 'placebo response', 'spontaneous regression' and 'expectancy effect' are no less metaphysical as those given for healing phenomena.

Grad (Grad, Cadoret, & Paul 1961) worked with a recognised "healer", the retired Hungarian army office Oskar Estebany. Estebany was to be the source of a variety of successful and elegant healing experiments with plants and mice, some of which were replicated (Solfin 1984). These experiments were carefully controlled and hastened growth or healing. Smith (1972), a Franciscan nun and bio-chemist worked with Estebany to test the hypothesis that any healing force channelled through, or made active by, the hands of a "paranormal" healer must affect enzyme activity.

At first she compared the effects of laying on of hands by Estebany on the activity of the enzyme tryspin. Solutions of trypsin [1] were divided into four samples; one sample was an unaltered control state, one sample was treated by Estebany in the same way in which he treated patients by laying on hands [2], another was exposed to ultra violet light [3] for sufficient time to reduce the activity to 68-80 per cent (Grad had suggested that an "unhealthy" enzyme be treated), and then treated by Estebany; one sample was exposed to a high magnetic field [4] for hourly increments for up to three hours.

The qualitative effect of a high magnetic field and a paranormal healer on the enzyme trypsin were similar, and quantitatively the same, in that enzyme activity increased up to one hour of exposure. Smith (1972) while warning

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[1] 500 ug per ml in 0.001 N HC1, pH3

[2] putting his hands around a stoppered flask containing the enzyme solution for a maximium of 75 minutes from which 3ml portions were pipetted out after 15,30,45 and 60 minutes.

[3] 2537 Ångstrom

[4] 8-13,000 gauss

against drawing too close a parallel between magnetic field effects and similar treatment effects from a healer, suggests that both forces bring about a change in organisation of hydrogen bonding in the molecules bringing about a higher enzymic activity. It is this organizing force that is assumed to be the healing principle.

This work was repeated with three people who claimed to have no healing powers, and three who did. They had no positive effect on the enzymes. Neither did Estebany when an attempt was made to replicate the experiment. His failure was attributed to his state of mind at the time not being conducive to healing. However, later three recognised healers were able to alter the enzyme according to spectro-photometric analysis in the way that Estebany had done. The quantitative effect varied daily according to the physical or emotional state of the healer. Further experiments with other enzymes [5] resulted in a decrease in activity or an inability to influence activity. The author argues that for the amylose this was a good sign in that a change in the amylose amylase balance would not be conducive to healing. In all Smith (1972) believes that the effect of laying-on-of-hands on enzymes contributes to the healing process.

A nurse researcher Krieger (Krieger 1979), taking up the challenge to demonstrate healing by laying on of hands in living human beings rather than in the test tube, made a series of before and after studies on human subjects. Like Smith before her, she was influenced by the work of Grad and Estebany. As the dependent variable she took haemoglobin values. Haemoglobin values did appear to respond to both Estebany in the initial experiments and to a small group of nurses whom Krieger trained in the art of laying on of hands (she called it "therapeutic touch"). Furthermore there is anecdotal evidence that the well-being of the patients improved.

[5] nicotinomide-adenine-dinucleotide and amylase-amylose

Other authors (Benor 1990b; Solfin 1984) have searched the available literature and presented the variable results of healing initiatives. Most of the studies have fallen by the wayside because of poor research design. While there appears to be material evidence for an intentional healing effect, the energetic correlate of that effect proves to be elusive to measurement in both the laboratory and the clinic. Much of this difficulty seems to be caused by the literal expectation of a material energy and the need for a materialistic causal explanation. As we shall see in the following section, the traditional systems of medicine have not divided material and spiritual causation.

An historical perspective

Medicine has a system of explanations for what it does. These are predominantly scientific, and it was this coherence of cogent ideas that was influential historically in the separation of scientific medicine from the influence of the church and metaphysical notions of healing. Historically, ideas regarding healing fell into two main schools. Ritualistic healing, whereby people fall ill, and are restored to health, through psychic or spiritual forces. Mechanistic healing; where people become ill following over-indulgence, sitting in damp places or changes in the weather and are restored to health by purges, diet and the unblocking of energies.

The sacred disease "epilepsy", which included hysteria and demonic possession, believed to be caused by the entry of the gods into mortal bodies to serve divine purposes, was challenged in the fifth century (Inglis 1979) as the invocation of divine elements masked the inability to provide effective treatment. With the questioning of spiritual causation then material causes were sought, the consequence of which was the theory of the "four humors" that must be balanced to maintain the status of

health within the body. These theories eventually led to modern physiology and allopathic remedies.

Throughout the last two thousand years Christian healing, reviving vitalist theories and shifting away from Greek concepts of hygiene, survived under the threat of Roman persecution by inspiring followers by acts of healing and other inspirational gifts. Christ's injunction to his disciples was to heal the sick. Although sickness was caused by sin, or loss of faith, the restoration of faith through acts of repentance and the sacrament of healing could restore the person to health. In these early accounts body and soul were not separate. A soul restored to holiness (wholeness) - the root word of health and healing- was also a healthy body. In these terms wholeness means a return to unity with God and is achieved by the action of the spirit. Thus healing as a restoration of souls in their unity with God became an important element in the early evangelical endeavour. Such an ecological understanding is not far from modern (w)holistic understandings) (Bateson 1991) but is far removed from humoral or physiological explanations.

As Christianity gradually became accepted and established, healing, which depended upon individuals being inspired by the spirit as opposed to being licensed by law, was seen as a threat to the hierarchy of the church. Eventually, in the twelfth century, Pope Alexander was to ban spiritual healing as a suspect activity inspired by the devil to seduce unwitting clergy to deal with matters of the flesh, and all its temptations. Such material concerns were best left to physicians.

Furthermore, the physicians began to organise themselves into guilds and medicine itself became began to form itself into a body of knowledge replicable in university centres throughout Europe. Metaphysics became increasingly idiosyncratic and open to individual interpretation and sentimentality. Christianity surrendered the sole authority to speak of life, birth and death to a materialistic science that verified human life in the same way in which it verified the physical universe (Needleman 1988). Understandings of the body and its relation to illness were transformed in the seventeenth century by the ability to dissect corpses (Foucault 1989) which led to a different classification for disease.

Supernatural explanations and causative forces were rejected in favour of theories within the realm of material phenomena according to the status of the internal organs. However, what was missing from such observations of the dead, were the vital forces necessary for living. Similarly academic medicine in the universities became separated from the empirical practice of clinicians observing the effects of their ministrations. Any understanding that the human body could be organised by subtle forces, and represented the presence of a higher intelligence in the universe, was abandoned (Hossein Nasr 1990).

Ancient systems of healing were based on the dynamic notion of energy (Leskowitz 1992) as such a life force. Fire energy; brought warmth through the principle of motion. Hidden energy, as air, was the sustaining energy and the activator of fire energy that used as its vehicle the blood stream, thereby maintaining the chemistry of life and conveying the vital energies of the body. In addition there were three forms of energy distribution; through the seven energy centres, which served as points of reception and distribution throughout the physical body; through the seven major glands of the endocrine system; through the nervous system. Restriction or inhibition of the free flow of these energies creates an imbalance or disharmony in the others. Health could be restored by releasing the cause of the blockages, also through the application of specific musical tones, to restore the flow of energy.

If we look at traditional Indian forms of medicine, Aryuveda and Unani (Greco-Arabian), we have a vitalist

epistemology based upon the physician as activator of the seven natural principles that administer the body (elements, temperaments, humours, members, vital breaths, faculties and functions) (Verma & Keswani 1974). In this sense, after Hippocrates, "Nature heals; the physician is nature's assistant". Breath is an important factor in activating the patient. Vitality itself derives from *viva*, "Let him live". Such a living force is carried by the breath. Breath and spirit share the same root, in Latin *spirare*, which later becomes *spiritus*, life breathed as the Holy Spirit. Life has the quality of inspiration and is heard in biblical texts as "*I am the Breath of Life*". Similarly the Greek *anemos* and the Latin *anima* are translated as wind and breath. Thus we have the ideas of vitality and animation being achieved through the inspiration of the breath, or *pneuma* in Unani medicine, which is the conveyor of the spirit (see Figure Three) and activates, through its parts, particular systems. Today Aryuvedic medicine and yoga use the regulation of breathing as an important factor in healing.

Figure Three: The action of pneuma (breath) in the body

vital pneuma	formed in the heart and conveyed through the arteries	all vital activities
animal pneuma	located in the brain and transported by the nerves	intellect, sensation, dynamic and movement
natural pneuma	located in the liver and transported by the veins	sensual desire, nutrition and blood formation

If we return to the roots of the everyday words that we use in medicine then we see that spiritual considerations, as they relate to meaning hope and purpose, are not strange. Patient is derived from the Latin *pati*, which is to suffer and patiently endure. Doctor is the teacher who discerns, from the Latin *docilitas*. Therapy is attentive support from the Greek *therapeutikos*. Therapist and doctor accompany the patient in their suffering along the way. The responsibility of the healing practitioner is to reach out to the patient, and that of the doctor is to discern and to teach. Such a stance is not solely concerned with cure, there are also the possibilities of relief from suffering and comfort for the sick.

Medicine, from the Latin root *medicus* is the measure of illness and injury, and shares the Latin *metiri*, to measure. Yet this measurement was based on natural cycles and measures. To attend medically, Latin *mederi*, also supports the Latin word *meditari* from which we have the modern meditation, which is the measuring of an idea in thought. The task of the healer in this sense is to direct the attention of the patient through the value of suffering to a solution that is beyond the problem itself--the idea of transcendence as mentioned at the beginning of the paper. In this sense, the healer has the power to change the sign of the patient's suffering from negative to positive.

Shamans, present in most tribal cultures throughout the world, were a spiritual elite who used techniques of ecstasy (dream and trance) to cure people, to guard the soul of the community and to direct its religious life (Eliade 1989). While trances were used to cure, they were also a means of transporting souls to other worlds and in mediating between humans and gods. The recruitment of such healers was by inheritance or spiritual vocation, entailed an arduous apprenticeship, and an initiatory crisis that involved the novice shaman being cured of a sickness (see Figure Four).

Figure Four: Differences between health practitioners, modern spiritual healers and traditional shamans

Health practitioner	Modern spiritual healer	Traditional shaman
Self-selection to a professional group	Self-selection often to a group, or by nomination within a hierarchy	Selection by crisis or inheritance
No initiatory crisis, pathological crisis a hindrance to vocational training	No initiatory crisis necessary, but concept of 'wounded healer' plays an important role	Initiatory crisis sign of vocation, pathological crisis necessary for vocation
Personal quest acceptable	Personal quest valued	Personal quest devalued or irrelevant
Institutional training	No institutional training necessary	No institutional training
No arduous mental and physical ordeal	No arduous mental and physical ordeal	Arduous mental and physical ordeal
Limited apprenticeship	Brief apprenticeship	Long apprenticeship
Legitimacy bestowed by institution on behalf of the community (licensing)	Legitimacy bestowed by community	Legitimacy bestowed by community
No kinship ties	No kinship ties	Kinship ties
Variable status	Low status	High status
Patient removed from environment, often treated behind closed doors, with the focus on individuals or dyads (rarely as family or social groups).	Patient removed from environment, often treated behind closed doors, with the focus on individuals or dyads (rarely as family or social groups).	Patient treated within the community as public phenomenon
Patient is the agent of their own healing and responsible	Spiritual forces or energy channelled by the healer is the agency of healing, patient responsible	The shaman is the agent of cure and responsible for the results
The patient takes the drugs	The patient receives the healing	The shaman takes the drugs
There are time restraints to consultation	There are flexible time restraints to consultation	No time restraints to consultation
For the individual good of the patient	For the individual good of the patient	For the social good of the community
For the material or personal gain of the therapist	For the material, personal or spiritual benefit of the therapist	A sacred event for the community with no personal benefit

Some modern day healers like to think of themselves as caretakers of this spiritual legacy of the shaman. However, any such notion is a rather misguided romantic fantasy revealing more about the healers need for power and reward than the role of healer in present day culture. Modern medical practice with its long initiatory training, rigid hierarchy, family expectations of sons and daughters to follow in the footsteps of a parent, the veneration by the community and the abuse of alcohol and drugs by its practitioners has far more in common with shamanic practice

Older 'shamanistic techniques' of healing have all but died out in Europe except for remote rural areas in Northern Europe (Vaskilampi 1990).

Spiritual, Mental and Energetic Healing Today

Spiritual healing still exists throughout Western Europe (Sermeus 1987; Visser 1990), and occurs in two main forms. The first involves a hand contact, or near contact, between the healer and the patient. This is also seen in the church ritual of the laying on of hands'. The second form is absent or distant healing where a healer or group of healers pray or meditate for the patient who is absent from their presence. Patients can be far removed from the healing group. Healers emphasise that a special state of mind is required for this influence to occur.

During this century there have been new calls for a healing revival from some church groups. This has culminated within the last decade with a recognition of the Christian churches healing ministry, albeit contentiously, and is often associated with a general interest in complementary medical initiatives calling for a consideration of the 'whole person'. There are also spiritual healing groups who have no church or religious affiliation and whose sole existence is the pursuit of spiritual healing.

In England these various spiritual healing organisations, and some religious groups, have formed themselves into a confederation of healing organisations so that they can practice in hospitals and take referrals from physicians. This confederation issues strict guide lines for practice and conduct (1990) which have been worked out with the help of the British Medical Association and the varying Royal Colleges. The code of conduct covers legal obligations, how to handle the relationship with the patient regarding medical treatment and emphasises full co-operation with medical authorities. There are clear guide lines for healers visiting hospitals, which include instructions about not wearing white coats, how to behave on the ward and how to obtain permission from the nursing officer. Unlike doctors, healers must disclaim an ability to cure but offer to attempt to heal in some measure, without any promise of recovery. If healing

should take place in such stringent conditions of psychological pessimism, then criticisms that these methods rely on 'patient suggestibility' must surely be found wanting. In addition the above federation of healers has several clinical controlled trials underway and a randomised double blind trial protocol for clinicians who are willing to co-operate (Benor 1990a).

Legal Considerations

That there are varying schools of medical practice, and beliefs, other than the orthodox is accepted in American Law. John Baumgartner was treated at his own request for acute prostratis by a Christian Science practitioner and a Christian Science nurse. Ten days elapsed before he died. No medical doctor was called in. He was a wealthy industrialist and bequeathed one half of his estate to the Christian Science church. His family objected and brought a wrongful death action against the church, the practitioner and the nurse. However, the court dismissed the case for medical malpractice on the ground that one form of medical practice cannot be judged by the criteria of another form of medical practice. In this case Christian Science practitioners were using spiritual means, not medical aid. The patient had specifically requested Christian Science treatment when he became ill, despite advice during his illness to seek medical aid, and could not have reasonably expected anything other than spiritual healing (Tammelleo 1986).

In recent years this ruling has been challenged with children with attempts to limit state legislation protecting the rights of religion and spiritual healing as a legal defense when children are refused medical care (Bullis 1991; Sibbison 1992). Parents risk prosecution when their children become ill and die if they rely on prayer to heal disorders and shun medical care. While convictions for manslaughter have been obtained in Massachusetts and California, and a conviction of third-degree murder in Florida, a recent ruling by the Supreme Court (Sibbison 1992) approved a Minnesota court decision exonerating the parents of manslaughter charges following the death of their son.

Conclusion

Clearly, in our modern cultures several belief systems operate in parallel, and can co-exist. Patients have begun to demand that their understandings about health play a role in their care, and practitioners too are seeking complementary understandings. As researchers and clinicians we must act as anthropologists in the search for meanings to understand behavior.

Neither of the orthodox traditions, be it church or medicine, can explain how healing occurs. Nor will either until we begin to accept that our knowledge is wanting and our searching is misguided. Healing research or clinical outcome trials only measure the products or efficacy of healing endeavours. Our spiritual understanding of the intention of healing is lost. While we may know the social implications of healing; i.e. integration into the community, improving and maintaining the available pool of labour; and the psychological implications of healing; i.e. happier contented patients (Fehring, Brennan, & Keller 1987) relieved of distress and sexually satisfied (Malatesta et al. 1988), we remember little of the spiritual intentions of healing. Miracles had a deeper purpose other than the restoration of physical health. It is not that the age of miracles is past, rather that the spiritual understanding is hidden and has been supplanted by material and emotional satisfactions alone (Shah 1964).

As yet we cannot understand healing energy through effectively measuring its properties, although its effects may be accessible to bioassay.

Perhaps what is more important, we systematically fail to define health. Recent considerations of holistic health or whole person medicine have included the idea of well-being and the unity of body, mind and spirit. Gregory Bateson (Bateson 1991) reminds us that it is difficult to talk about living systems that are doing well. It is easier to describe living systems when they are disturbed, thus separating the parts and thereby losing the necessary connection. While dissecting the corpse brought an important understanding of the anatomy of the body in terms of the geometry of its parts, the necessary connections of those parts in the dynamic processes of living were lost. This restoring of connection, the making of the completed whole, is the task for which we are prepared as practitioners and healers, yet eludes our descriptions as scientists and researchers.

Finally, I must point out that this paper is not an evangelical tract on behalf of spiritual healing. The reader is not being asked to change his or her belief system, merely to acknowledge that what the patient believes is of importance and will have an influence on the way in which health initiatives are accepted and maintained. Furthermore, prayer is seen by many cultures as an important activity in the maintenance of well-being, as a coping response in times of stress, as a healing activity and as a source of comfort. To ignore such a powerful agent with the elderly, the dying and the chronically ill is a folly. Removing the pillar of spirituality from our culture is absurd as removing the pillar of science.

Illness may be seen as a step on life's way that brings us in contact with who we really are. The positive aspect of suffering has been neglected in our modern scientific culture such that we, as practitioners and patients, search for immediate relief. This is not to advocate suffering, rather to emphasise that we do not lose the potential of suffering for transformation of the individual. To accept the teaching of suffering, while pursuing relief from that suffering and comforting the sick, would also restore the doctor to the status of teacher.

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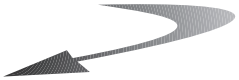

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