Spiritual Aspects of Management

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Abstract

There has been increasing interest in spirituality in recent years. In this chapter, spiritual aspects of psychiatric management are considered in the context of cultural psychiatry, demonstrating how spirituality is integral in the practice of psychiatry. The meaning of spirituality and religion, and how they are relevant to psychiatry is discussed. There is now much evidence linking religious/spiritual belief and practice to better mental health outcomes. Spiritual assessment is a clinical skill and mental health professionals should pay more attention to the spiritual needs of patients. Contributions to spiritual management are also made by chaplains, service users and carers. Spiritual management is complementary to other methods of psychiatric treatment and benefits the whole person. There is no place for imposing the world view of the psychiatrist upon the patient (whether that be an atheistic, traditionally religious, or spiritual belief system). Each psychiatric condition requires different management. Some of the many specific techniques used in spiritual healing are described. Spiritual management is not another addition to the menu of possible treatment regimens, it is an attribute of the physician that is all pervasive and affects every part of practice.

Key words

Spirituality	Healing
Religion	Outcome
Management	Mental health & illness
Mental health services	Assessment of spirituality
Mental health professionals	Users, carers, chaplains

Introduction

The significance given to the religious or spiritual concerns of the patient reflects the culture of psychiatry in that place, and time. In Europe and North America, it is a product of the long-term ideological conflict within psychiatry between reductionist tendencies and a philosophy of assessment and treatment that aspires to help the whole person. Both of these extreme positions have made contributions to the effective treatment of patients, and probably some degree of dynamic tension has been beneficial to the academic discipline of psychiatry. Most practitioners have learnt from both schools of thought, and apply an amalgam in their clinical practice. In recent years there has been much more interest in spirituality by psychiatrists throughout the world, and this has been recognised by the World Psychiatric Association as well as at national level (Leon et al., 2000).

There have been major changes within psychiatry towards the concepts of spirituality and religion over the last half-century. For example, in the standard British textbook of psychiatry in the 1950s through to the 1970s[1], there are only two references to religion in the index: "'Religiosity' in deteriorated epileptic", and, "Religious belief, neurotic search for" (p180). The latter was aimed as an attack upon psychoanalysis but assumed religion is for "the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life". The attitudes of those influential in psychiatry tended to regard religious belief in patients as 'neurotic' and in doctors as unscientific. By contrast, in the early 21st century, the Spirituality and Psychiatry

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[1] This appeared in the 1st, 2nd and 3rd Editions of *Clinical Psychiatry* by Meyer-Gross, Slater and Roth in 1954, 1960 and 1969. See, for example, the 3rd Revised Edition by Slater and Roth, 1979. Insofar as the standard textbooks are concerned, it would appear that little has changed. In the 2nd Edition of the New Oxford Textbook of Psychiatry (Gelder, Andreasen, López-Ibor and Geddes, 2012), there are still only two entries for "religious", respectively for "religious delusions" and "religious healing ceremonies".

Special Interest Group is one of the largest and most active special interest groups in the Royal College of Psychiatrists (Powell and Cook, 2006), and the College has published two books devoted to spirituality and psychiatry (Cook et al., 2009, Cook et al., 2016).

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This chapter aims to put spiritual aspects of psychiatric management into the context of other types of psychiatric management and cultural psychiatry. The intention is to demonstrate how spirituality should be included as part of the theory and practice of the management of psychiatric disorders and how it fits into the complete picture of the treatment of patients.

Case examples are given to demonstrate what spiritual aspects of management mean in clinical practice. What is meant by spirituality and how it is relevant to the practice of psychiatry is discussed. How spiritual aspects of management complement other conventional methods of psychiatric treatment to benefit the whole person, both with the alleviation of symptoms and an improved ability to function appropriately is also covered. There is brief description of some of the vast range of specific techniques used in spiritual healing. Mental illness subsumes a number of different psychiatric conditions and the relevance of spiritual aspects for these different diagnostic entities is considered. Pastoral care and user initiatives are explored and conclusions are drawn for the relevance of spiritual attitudes in the treatment of psychiatric patients.

Definitions

"Spirituality" is a useful, very imprecise word; perhaps useful because it does have varied meanings for different people. Dictionary definitions are not particularly

helpful, and numerous definitions abound in the academic literature.[2] According to the Dalai Lama:

> Spirituality [is] concerned with those qualities of the human spirit – such as love and compassion, patience, tolerance, forgiveness, contentment, a sense of responsibility, a sense of harmony – which bring happiness to both self and others. (Gyatso, 1999, p.23)

More comprehensively, spirituality may be defined as:

> a distinctive, potentially creative, and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately "inner" immanent and personal, within the self and others, and/or as relationship with that which is wholly "other", transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values (Cook, 2004, pp.548-549)

It is sometimes suggested that religion is easier to define, but in fact religion is also a complex concept not susceptible to simple or uncontested definition (Bowker, 1999, pp.15-24). Similarly, it is often compared unfavourably with spirituality, the former being represented as more individual, subjective and "authentic", the latter as more collective, institutional and rule bound. In fact the relationships between spirituality and religion are complex, the two concepts being inseparable for some people and representing contrasting opposites to others. The tendency to adopt a position of being

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[2] Some of these are reviewed – mainly in relation to addiction psychiatry – in Cook, 2004.

"spiritual but not religious" (Casey, 2013) is a relatively recent western phenomenon and would not make any sense at all historically, or in many parts of the world today (e.g. in Islamic countries or in India). However, it represents a separation of spirituality from religion which is an important consideration in psychiatric practice. A patient may not consider herself to be "religious" in any traditional sense, and may not affiliate with any faith community, but may yet consider spirituality to be at the heart of her priorities, values and purpose in life.

Spirituality and Mental Health

There is now considerable research evidence for the effects of religious belief, or spirituality, upon health and disease. This has been systematically collated by Koenig et al in two editions (better seen as Volume 1, reviewing studies up to 2000, and Volume 2, reviewing subsequent studies) of the *Handbook of Religion and Health*[3]

The 1st edition of the *Handbook* reviews and discusses research that has examined the relationships between the patient's religious beliefs and a variety of mental and physical health conditions. It covers the whole of medicine, and is based on 1200 research studies and 400 reviews. Research on Religion and Mental Health occupies 10 chapters. Under *research and mental health* are discussed: religion and well-being, depression, suicide, anxiety disorders, schizophrenia and other psychoses, alcohol and drug use, delinquency, marital instability, personality, and a summarizing chapter on understanding religion's effects upon mental health. The authors are cautious in drawing conclusions but the results are overwhelming. To quote:

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[3] Koenig, McCullough and Larson, 2001, Koenig, King and Carson, 2012

In the majority of studies, religious involvement is correlated with:

- Well-being, happiness and life satisfaction;

- Hope and optimism;

- Purpose and meaning in life;

- Higher self-esteem;

- Adaptation to bereavement;

- Greater social support and less loneliness;

- Lower rates of depression and faster recovery from depression;

- Lower rates of suicide and fewer positive attitudes towards suicide;

- Less anxiety;

- Less psychosis and fewer psychotic tendencies;

- Lower rates of alcohol and drug use and abuse;

- Less delinquency and criminal activity;

- Greater marital stability and satisfaction…

We concluded that, for the vast majority of people, the apparent benefit of devout religious belief and practice probably out-weigh the risks. (Koenig et al., 2001, p.228)

Correlations between religious belief and greater well-being *"typically equal or exceed correlations between well-being and other psychosocial variables, such as social support"* (*Ibid*, p215). That is a considerable assertion, comprehensively attested to by a large volume of evidence, for example, in Brown and Harris's (1978) studies on the social origins of depression, various types of social support were the most powerful protective factors against depression.

80% or more of the studies reported an association between 'religiousness' and greater hope or optimism about the future. 15 out of 16 studies reported a statistically significant association between 'greater religious involvement' and a greater sense of purpose or meaning in life. 19 out of 20 studies reported at least one statistically significant relationship between a religious variable and greater social support. Of 93 cross-sectional or prospective studies of the relationship between religious involvement and depression, 60 (65%) reported a significant positive relationship between a measure of religious involvement and lower rates of depression; 13 studies reported no association; 4 reported greater depression among the more religious; and 16 studies gave mixed findings. With all the 13 factors, religious belief proved beneficial in more than 80% of mental health studies. This is despite very few of these studies having been initially designed to examine the effect of religious involvement on health.

The authors develop a model for how and why religious belief and practice might influence mental health. There are direct beneficial effects upon mental health, such as better cognitive appraisal and coping behaviour in response to stressful life experiences. There are also indirect effects, such as developmental factors and even genetic and biological factors.

Most of the studies were carried out in the USA and most subjects have belonged to the Judeo-Christian tradition. There is some work from other countries and other religions, and the results are similar. At our present state of knowledge it is important

to have more sophisticated measures of religious and spiritual belief for psychiatric research[4].

The 2nd edition of the Handbook largely supported the overall findings of the 1st edition (Cook, 2012). Disappointingly, the authors found that there had been no overall improvement in the methodological quality of research published in this field, but this should not be allowed to distract from the many high quality studies that are now being published, and the authors found that the better quality studies were more likely to report positive relationships between spirituality/religion and health. Overall, at least two thirds of studies reviewed were found to demonstrate positive relationships between spirituality/religion and emotional and social well-being and healthier lifestyle.

Religious belief and practice is associated with decreased rates for suicide (Cook, 2014), with decreased rates of delinquency (Benson and Donahue, 1989), with higher rates of marital stability (Call and Heaton, 1997), lower rates for hostility (Kark et al., 1996), more hope and optimism (Mickley et al., 1992), and an internalised locus of control (Jackson and Coursey, 1988). As an example of the association with well-being, a questionnaire was administered to 474 students in the United Kingdom enquiring about religious orientation, frequency of personal prayer and church attendance, alongside measures of depressive symptoms, trait anxiety and self-esteem (Maltby et al., 1999). Frequency of personal prayer was the dominant factor in a positive relationship between religiosity and psychological wellbeing.

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[4] See, for example, King, Speck and Thomas, 2001. However, it is interesting that use of their instrument in UK and European samples has produced somewhat different results than those most commonly seen in US studies (e.g. King, Marston, McManus, Brugha, Meltzer and Bebbington, 2013)

Whilst there continues to be debate about the strength and interpretation of the evidence, there is now sufficient recognition of the link between spirituality/religion and mental health that various national and international professional bodies, including the Royal College of Psychiatrists (Cook, 2013b) and the World Psychiatric Association (Moreira-Almeida et al., 2016) have implemented policies concerning the part played by spirituality/religion in psychiatric training, professional development, and clinical practice.

Assessment of spirituality

As part of clinical assessment it is recommended that the doctor take a spiritual/religious history, perhaps employing questions such as those illustrated in Box 1.

(Box 1 about here)

Box 1: Questions that may be used in the assessment of spirituality/religion in clinical practice[5]

- Is religion or spirituality important to you?

- Do your religious or spiritual beliefs influence the way you look at your medical problems and the way you think about your health?

- Would you like me to address your religious or spiritual beliefs and practices with you?

Patients are more likely to have confidence in their psychiatrist if he or she demonstrates a sympathetic attitude toward their beliefs. Ascertaining spiritual belief

[5] Matthews and Clark, 1998, p274. For a more extended discussion of the assessment of spiritual needs, see Culliford and Eagger, 2009

is also a vital ingredient of the mental state examination of the patient and gives valuable information for assessment and treatment. The psychiatrist therefore needs to give validity to the patient's beliefs. This will imply being able to discuss belief with the patient in the context of their psychiatric symptoms. It may mean a preparedness to confer, at the patient's request, with a designated religious leader or chaplain. It will mean acknowledging the value of prayer to the patient and of the benefits of a faith community such as a church, synagogue or mosque.

Spirituality in the management of psychiatric disorder

Spirituality and religion are often neglected in clinical practice when planning the management of psychiatric disorders. We, as psychiatrists, purport to deal with the whole person, and psychiatrists have sometimes criticised the orthopaedic surgeon who treats 'a knee' in isolation, or the renal physician who cannot see beyond the deranged physiology of the kidney.

> We psychiatrists complain when our medical colleagues cannot get beyond the physical, even when evidence for psychosocial aetiology is quite blatant, but we may be guilty of an equivalent error in almost totally excluding spiritual considerations from the way we understand our patients. (Sims, 1994)

That was written more than 20 years ago, but it is still to some extent true.

A robust comment on the need of mental health professionals to take spiritual aspects of their patients into account is made by Swinton (2001). Our patients are

apprehensive because of the hostility psychiatrists have shown in the past towards their religious beliefs. They want psychiatrists to acknowledge these beliefs and integrate them into treatment. There is a "religiosity gap" between patients, who are more likely to be religious, and psychiatrists, who are more likely to be atheist or agnostic (Cook, 2011). Mental health practitioners show consistently lower rates for religious beliefs and practice than either their patients or the general population.

There is much encouragement for psychiatrists to work with other disciplines in the care of their patients, both practising in a multi-disciplinary team and collaborating with other, external agencies. Religious people and organizations are often very helpful, sometimes providing the only spiritual support for psychiatric patients, and optimum care should therefore, at least on occasion, involve working more closely with them. This point was made cogently by Lord Carey, when Archbishop of Canterbury, in an address jointly to the Association of European Psychiatrists and the Royal College of Psychiatrists (Carey, 1997).

The onset, course, outcome and treatment for the various psychiatric disorders are markedly different, and therefore so should be the spiritual aspects of their management. Little attention has been paid to this in the past. For those with mental disorder there is, in general, a better outcome if the patient has religious belief; this is true for most individual psychiatric conditions (Koenig et al., 2001, Koenig et al., 2012). It pertains, for example, for schizophrenia (Verghese et al., 1989), depression (Kendler et al., 1997), anxiety disorders (Koenig et al., 1993), and substance use disorders (Cook, 2009).

It would therefore appear helpful both for mental health professionals to pay more attention to the specific spiritual needs of different types of patients, and for religious leaders, such as hospital chaplains, to take psychiatric diagnosis into account to a greater extent in their pastoral work. Spirituality and religion are also important factors to be taken into account by carers and mental health service users themselves.

Mental Health Professionals

Spirituality and religion impact upon the management of different psychiatric disorders in different ways.

Patients with *dementia* may have specific spiritual needs. These result from loss of awareness and relatedness to God's transcendence, loss of sense of meaning, hopelessness, loss of meaning, purpose and value; and, apparent disinterest in the spiritual dimension [6].

Depressed patients may have all-pervasive feelings of guilt and self-blame; they may believe that they have committed the unforgivable sin or will be consigned to eternal punishment. On occasions such religiously inspired beliefs have been dispelled with anti-depressant medication and/ or electro-convulsive therapy. On the other hand, depressed people with firm religious convictions, and their relatives, are frequently terrified of psychiatric treatment because they anticipate psychiatric staff being antagonistic to religion and challenging their beliefs. Sadly, there has been justification for their fears in the past (see page 14).

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[6] **Lawrence RM & Raji O** (2005) Introduction to spirituality, health care and mental health.
www.rcpsych.ac.uk/spirit

Religious delusions are not infrequent with *schizophrenia* and whilst it has been argued that they more often occurred in the past (Klaf and Hamilton, 1961), worldwide the frequency of religious delusions may not be declining (Cook, 2015b). The frequency of this association does not imply that religion causes delusions but rather that delusions tend to take on the content of the sufferer's prevailing interests and concerns. A skilful clinician will find the middle ground between appearing to accept the delusional ideas and diminishing the patient's self-respect and confidence in the doctor by rejecting them – avoiding collusion and confrontation.

Cognitive behavioural therapy (CBT) and other forms of psychological treatment can work with the grain of religious belief in the treatment of *anxiety disorders*. Using the patient's own beliefs, the patient debates within himself to correct his own negative thinking. Religiously and/or spiritually integrated CBT is now being developed and studied in application to anxiety disorders (Rosmarin et al., 2010, Williams et al., 2002), obsessive-compulsive disorder (Akuchekian et al., 2011), affective disorders (Koenig et al., 2015), and substance use disorders (Hodge and Lietz, 2014).

Faith, and religious conversion, has proved of great benefit to some people trying to recover from their *addiction to alcohol or other drugs* (Cook, 2009). The spiritual programme of the Twelve Step organisations (Alcoholics Anonymous, Narcotics Anonymous, and the other related "Anonymous" groups) has been particularly important in the recovery of many people from substance use disorders and is accessible to people from all faiths and none. The so-called "Higher Power" does not have to be religiously interpreted and many agnostics and atheists report having found these programmes helpful (Dossett, 2013).

A more extended account of the spiritual aspects of different psychiatric conditions is to be found in Swinton (2001). Some of the questions concerning the ethical implications and the nature of good professional practice are addressed by (Cook, 2013a, Cook, 2015a). In particular, it is important to recognise here that addressing spiritual/religious concerns in the assessment and treatment of psychiatric disorders should be a patient-centred exercise, and that this does not allow any place for proselytising or imposing the world view of the psychiatrist upon the patient (whether that be an atheistic, traditionally religious, or spiritual belief system).

It was not infrequent in the past for some psychiatrists, not realising that they were expressing their own religious opinions, to disparage and denigrate their patient's religious beliefs. This is vividly described by Jean Davison (2009) in her book, *The Dark Threads*. Jean was a Christian teenager treated as an in-patient in a mental hospital in the 1970s. She describes how different psychiatrists repeatedly belittled her faith – until, sadly, she abandoned it:

> If they wanted me to relinquish all thoughts of God, why didn't they try to help me see that life could be bearable, even happy, without a God to believe in? Instead they kept on subjecting me to 'treatment' which made me cry out in desperation to this remote, perhaps fictitious, 'God' to help me. More than ever before I wanted and needed Him now. (p138)

When Jean was first admitted to hospital, her doctor said to her:

"Hell doesn't exist. The Bible isn't meant to be taken literally: it's full of metaphors…Heaven doesn't exist either. The world's moved on from fairy tales to science." The doctor sighed, "But really, love, you ought to have had more sense than to try to believe things like that in the first place, don't you think?" (pp62-63)

In 2013, the General Medical Council published an updated version of its guidance on *Personal Beliefs and Medical Practice* (General Medical Council, 2013). This guidance does acknowledge a positive place for taking into account religious and spiritual beliefs in clinical practice, but emphasises that "you must not put pressure on a patient to discuss or justify their beliefs, or absence of them" (para 29). It further indicates that a doctor should not discuss their own beliefs with a patient unless this is initiated by the patient, or the patient clearly indicates that they would welcome such a discussion. Imposing beliefs on a patient, or causing distress by insensitive expression of them, is clearly warned against (para 31).

Frequently, patients have said that they were disturbed by their treating psychiatrist, during the course of psychiatric interview, attacking their religious beliefs, recommending that they discontinue their religious practice and disassociate themselves from their church or other affiliation. This has, of course, caused them enormous distress, and has often been an expression of the psychiatrist's atheist, secular views; it has certainly been an imposition of the psychiatrist's belief upon the patient. Belittling of patients' Christian beliefs by psychiatrists has been frequent to the extent that many church leaders discouraged their members from consulting a psychiatrist, sometimes to the considerable detriment of the potential patient. Such

"proselytising" is clearly as much a problem (if not more), and equally unacceptable, as proselytising on behalf of particular religious beliefs or traditions.

Chaplaincy

Within the National Health Service in the United Kingdom, Hospital or Community Mental Health chaplains are often employed. They are valuable in many ways, and often contribute to the treatment of patients. Another clinical case history illustrates this issue.

A 14- year old girl of Pakistani origin was referred to a child psychiatrist for school refusal, disturbed behaviour and vivid descriptions of frightening visual perceptions. The general practitioner thought that she might be psychotic. She and her parents were most concerned about her 'visions'. They had wanted to consult the imam but had discovered that he was out of the country. The child psychiatrist reassured them that she was not psychotic and, with the family's permission, arranged for her to discuss her strange experiences with the hospital chaplain. This seemed to work, as spiritual guidance was given and accepted.

Service Users and Carers

Psychiatrists, and other mental health workers, sometimes fail to realize that they are not the only people trying to help those with mental illnesses to cope better, feel some relief from symptoms and relate in a mutually rewarding way to others in the community. Identified mentally ill people, *users* in conventional jargon, make an increasing contribution in identifying the sort of services they require. Their close relatives and friends, *carers*, have over the last couple of decades shaped the

provision of services and individual patient contact in a beneficial manner. Religious organizations, in the British context especially churches, have always had involvement with the mentally ill and over recent years have approached their working with such people in a more systematic and knowledgeable manner.

An example of spiritual management in the contribution that users and carers themselves make to the care of those with mental illnesses is the Association for Pastoral Care in Mental Health. In a Newsletter, the Chairman queried:

> [How] might we… reduce the gap between the most traumatised and the normal person whoever that might be? Perhaps all we can share is what we have and who we are, our time and our love, that which is given freely and received freely – all God's gifts. Resolutions without the recognition of God's provision are empty resolutions, like works without faith are empty. We spend millions striving for the perfect manifesto but fail to provide that one essential ingredient that the whole nation is yearning for. "Love", without which as St Paul says, "We are nothing". By listening, ministering, nurturing, valuing and responding to the needs of the spirit, the journey begins – when we begin to walk, that's where the road starts.(Heneghan, 2005)

This is certainly a most important area of discourse. What is the significance of love in the management of the mentally ill? What does *love* mean in this context and how can this be provided by the individual mental health professional, the National Health Service, users and carers? This is too big a subject to embark on in this chapter but requires ongoing discussion (Sims, 2006).

Another example of user initiative in this area is the report *Knowing Our Minds*, published by the Mental Health Foundation (1997), which surveyed 401 people's experience of mental health services and treatments. The sufferers are considered to be the "primary experts" on their own mental health. Those surveyed recommended very strongly that mental health professionals recognise and take into account the spiritual aspects of mental health and its problems.

Churches in Britain have taken a positive position towards the treatment of the mentally ill in recent years and have taken steps to help such people and co-operate with statutory mental health services. Addressing psychiatrists, senior churchmen have recommended collaboration between psychiatrists and clergy for the benefit of sufferers (Carey, 1997), and have, noting the move away from a mechanistic view of man, recommended psychiatrists to take more care of their own spiritual and mental state (Hope, 2004). This does not imply any blurring of role between psychiatrists and priests. Rowan Williams, when Archbishop of Canterbury, recommended empathic and informed listening to patients (Williams, 2005). The Church of England has also produced a significant report on healing, which deals with the whole subject from a more theological perspective (Working Party on Healing, 2000).

Spiritual healing

Spiritual healing is a specific type of intervention involving acknowledgment of the importance of the spiritual dimension in the treatment of human illness and malaise.

Spiritual healing in the form of prayer, healing meditation, or the laying on of hands has been practised in virtually every known culture. Prayers and rituals for healing are a part of most religions. Reports of folk-healers are familiar from legend, the Bible, anthropological studies of traditional cultures, the popular press, and more recently from scientific research (Benor, 2001, p.3)

Spiritual healing was recognized as a form of complementary therapy by the House of Lords Select Committee on Science and Technology. In their classification it was placed in 'Group 2' of therapies used to complement conventional medicine without purporting to embrace diagnostic skills (House of Lords Select Committee on Science and Technology, 2000). Here, healing was defined as:

a system of spiritual healing, sometimes based on prayer and religious beliefs, that attempts to tackle illness through non-physical means, usually by directing thoughts towards an individual. Often involves 'the laying on of hands'.

Conventional medicine is not universally effective, for all people, for all illnesses and conditions, and at all times. That truism being immediately accepted by patients and doctors alike, patients will search for alternative and complementary therapies, sometimes those that conform better with their world view, and it behoves doctors to be open-minded, certainly to give cautious warnings when appropriate, but also to be humble in their claims. On occasions they should co-operate and collaborate for the benefit of patients.

The range of different types of spiritual healing is immense, and beyond the scope of this chapter to describe, or even list. Healing may take place at a distance or by laying on of hands. It may involve meditation and prayer by the subject. According to Fulder, the patient is encouraged to see healing as an enterprise towards health and self-discovery, rather than a cure for a specific illness (Fulder, 1984). Benor (2001) lists the following 12 systems of healing, which he has encountered and whose practitioners he has generally found reliable. He gives strengths and limitations for each:

- *Spiritual healing in religious settings*

- *Qigong healing*

- *Medical dowsing*

- *Reiki healing*

- *LeShan healing*

- *Therapeutic Touch*

- *Craniosacral therapy*

- *The Bowen technique*

- *Barbara Brennan healing*

- *Polarity therapy*

- *SHEN healing*

- *Healing Touch*

These are all available in USA, whatever their country of origin. Rees (2003) lists techniques of healing from all over the world, including his own country of Wales. The similarities between some of these methods from places far distant from each other are remarkable.

Overall, the evidence for efficacy of spiritual healing is positive, but only weakly so, not as strong, nor as unidirectional as the evidence for health benefits from religious belief and practice. Positive results are reported. For example, significant effects of healing on AIDS was demonstrated in a report of 40 sufferers randomly allocated to treatment and control groups with distant healing for 10 weeks from 40 experienced healers (Sicher et al., 1998). After six months the treatment group had significantly fewer AIDS-related illnesses and lower severity of illness with fewer visits to doctors, hospitalisations and days in hospital. However, although there are a large number of accounts of healing for human physical problems, overall the results are equivocal and many of the strongly positive studies have not been published in peer reviewed medical journals, nor replicated.

Conclusions

Spiritual management is not another addition to the overburdened menu of possible regimens with which to treat patients, or to the ever-increasing curriculum for hard-pressed psychiatric trainees. It is more an attribute of the physician that is all pervasive and affects every part of practice. It is particularly reflected in the capacity for insightful listening. Shooter (2005) has categorised this as: "listening with the ears, listening with the eyes, listening with the heart and listening with the hands, the latter perhaps what takes place in some types of spiritual healing".

Spiritual management is something, which should happen as part of the investigations and interventions of conventional medicine, in the same way that the general physician should take a drinking history and reckon to treat the patient taking

behaviour into consideration, and the psychiatrist should pay attention to the physical state of the patient. There is also a set of therapeutic techniques outside but complementary to medicine. Finally, spiritual management occurs in the work of other professionals, such as the clergy, with whom the doctor co-operates and collaborates for the benefit of their mutual patient. It is, therefore, an integral and essential part of cultural psychiatry.

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