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Abstract

Everyday experience shows that there is a commonality between spirituality and medical practice. A text message I received from a friend recently read, "Please pray for me. I've been getting a mysterious headache for some days now. I will be seeing the doctor today." This clearly speaks of a relationship: asking for prayer so as to be relieved of a "mysterious headache", yet going to see a doctor whose job is not to cure mysterious headaches. Even though both areas of human experience have their peculiar and largely unrelated methodologies, this paper argues that any extreme separation of the two is injurious to the teleology of both disciplines in relation to human well-being, which forms the core of spirituality and medicine.

Introduction

The question addressed in this essay is: what is the relationship between spirituality and medical practice? Even though it is not a new one, the question is pertinent for two reasons. First, it cannot be ordinarily conceived of that medicine, which is purely a science, has anything to do with spirituality. Spirituality is generally viewed from the prism of theology, and by extension, religion, even though these do not account for the whole truth about its source. Spirituality can also be experienced through non-religious means, eg music and tourism. Second, the methodologies of both areas of human knowledge and experience are also unrelated. While medicine has to do with objective, empirical analysis, and thus becomes "a purely mechanistic model" (1), spirituality is generally regarded as a subjective and private enterprise, which is largely intuitive. To make a connection between the two is, therefore, problematic.

Despite the differences, a closer examination of their historical evolution and the mounting volume of literature demonstrates a significant relationship. While medical practitioners, as human beings, are spiritual, patients are also spiritual. Just as the physician's ultimate aim is to cure patients of their diseases, the latter hope that this aim is fulfilled. Patients do not necessarily care whether or not they are cured through orthodox medication (just as drowning people do not care so much about who saves them or by what means they are saved).

We argue that there are limits to what medicine can know and do, just like spirituality, and that the two may collaborate in achieving a common human purpose. To help the reader grasp the thrust of this paper, the terms "medicine" and "spirituality/religion" are briefly defined. The paper also traces the roots of the hospital sign and grounds it within a theo-historical context. The relevance of prayer in medical spirituality and the type of relationship between the two is discussed. This brings us to the challenges in the relationship between spirituality and medical practice, and we make certain recommendations on how to overcome these. The paper concludes that physicians should be sensitive to their cultural, moral and religious landscape, which places a high demand on them.

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Clarification of terms

For a better understanding of the arguments in this paper, the terms medicine, religion and spirituality need to be defined briefly..

Medicine

Generally, medicine can be conceived of as "the study of the treatment of diseases and injuries" or a substance which one takes to cure an illness (2). Family medicine concerns itself with medical care of the whole person. This includes "an understanding of a patient's family and environment, as well as the social, cultural and psychologic situation" (3). It has been argued that spirituality forms an integral part of the psychological dimension of a person. This is important for the reason that family physicians are intensely concerned about the spiritual factor since it affects their patients' health. Corey Richardson puts it this way: "Health providers of every field are ethically bound to care for their patients to the best of their knowledge and ability to insure weliness (sic)" (1).

The ethical dimension of the medical profession is instructive as well as challenging for medical practitioners. Patients have the right to be given any new information that could lead to an improvement in their health. Let us hypothesise that a health provider knows about a new procedure or means that could lead to an improvement in the patient's health. However, he/she does not believe in this new method, or does not feel comfortable integrating it into the treatment protocol. If the patient dies as a consequence, should the health provider not be liable? This ethical construct guides Kazeem Sadegh-Zadeh's definition of medicine. According to him:

> *Medicine is a science and practice of intervention, manipulation, and control concerned with curing sick people, caring for sick people, preventing maladies, and promoting health. What necessitates this task is the human suffering that results from maladies, and the desire for remedy and relief. Medicine serves this human need by attempting to lessen human suffering that human beings evaluate as bad,*

> *and to restore and augment well-being that human beings evaluate as good…. Medicine as health care is practiced morality insofar as it acts against what is bad, and promotes what is good, for human beings. And insofar as it seeks rules of action toward achieving those goals and strives continually to improve the quality and efficacy of these rules, ie as clinical research, it belongs to normative ethics* (4).

The other crucial aspect of medicine refers to "the scientific study or practice of diagnosing, treating and preventing diseases or disorders of the body or mind of a person or animal" (5). The aspect of spirituality in the argument for a mind–body relationship in medicine is important, for the simple reason that the ultimate aim of medicine is to cure patients wholly of their illness, where illness refers to "the way in which people experience a disease or any biophysiological state that is an object of inquiry for the current medical practice" (6). Andrian Andreescu defines curing as "clinical recovery from disease" and healing, which refer to "how regained health is subjectively experienced by the former patient" (6). He goes on to say that since objective measures cannot always account for the emotional and social costs of disease or illness, healing should be regarded as a "fundamental aspect of a person's well-being and a necessary part of an authentic state of health" (6: p 25) (8). Thus, healing encompasses curing because "no curing is complete without healing, and healing might precede curing" (6: p 25). Benson Igboin argues that curing entails recovery at the observable/physical level, while healing is essentially inward and radiates through curing. It is a lived experience because it has to do primarily with the mind or soul. (7)

Rene Descartes and David Hume of the reductionist school argued that everything can be explained by understanding its components. This philosophy, which was borne out of the argument for a mind–body relationship, spread to science, particularly the methodological framework of medicine. It formed the basis of medical metaphysics. Sadegh-Zadeh argues that "part–whole relationships become tractable" through the construct of "fuzzy mereology" (4: p 6). In medicine, "separate organ systems were studied" so as to understand "how and why the body functions the way it does" (8: p 52). This reductionist compartmentalisation gave rise to specialisation in the medical field. It was also this philosophical model that most certainly led physicians to start the process of the "reincorporation" of spirituality into medical practice, because "the spiritual dimension may encompass everything in mind–body medicine" (8: p 59).

The debate on the mind–body interaction is still alive in philosophical circles. The extreme form of it is the denial of the existence of the soul or mind. While most theists and even philosophers believe in the existence of the soul, their position has drawn caustic criticism. This debate may not be too compelling in medicine because of the fact that it recognises the integrality of body, mind and spirit. This, however, does not nullify the argument on "how" and "where" the soul or mind exists. The prime objective of medical practice is the restoration of health and harmony among human beings. However, the question of "how" things work is a central focus of medical science. The implication of this scheme of things is that what is not known cannot be helpful in medical practice. Specifically, since medical knowledge cannot ascertain how spirituality works generally, and how it affects the health of patients positively, as it claims, the effect of spirituality can be refuted and one need not engage in in-depth scientific research to unravel the truth of these claims.

Robert Thomsen points out that physicians must be honest enough to acknowledge that their knowledge is clearly inadequate to tackle medicine according to the mind–body approach. In his words, "… we know in our hearts that even this [medical knowledge] would not be enough. There are some problems that are just not fixable by our skills and tools. There is a limit" (9: p1443). He elucidates, "When we cannot explain something, we tend to refer to it as psychosomatic and leave it at that. We acknowledge the spiritual, but deny it at the same time, because we have had no training experience in what to do in that arena." (9: p 1446) He goes on to say:

> *There are times too, puzzling times, when we know that we cannot help, and yet the patient gets better anyway, despite what we have done. Why? The answer eludes us, obviously there is more to our care than we are capable of understanding. There is what we sometimes call psychosomatics. This is the territory of spirituality*. (9: p 1443)

Andreescu defines psychosomatics as "a term widely accepted as referring to the inseparability and interdependence of psychosocial and biologic aspects of human beings" (6: p 28). He proposes the concept of psychosomatic plasticity proneness, according to which the psychosomatic potential of the individual can play a role in the healing process and can implicitly be used "to turn personal psycho-emotional content into a bodily reality" (6: p 28). He holds that it is through discrete mediation of the psychosomatic plasticity proneness that psychosocial factors contribute to the progression of disease or regaining of health. The foregoing analysis shows that when we describe medicine, we cannot do so exclusively in terms of mono-categorisations such as "medicine is a science" and "medicine is an art". We should, instead, conceptualise it in a more global perspective, which includes, but is not limited to, natural science, human sciences (theology, spirituality, religion, psychology, etc.), clinical research (4: p 6).

Religion and spirituality

Many authorities have used religion and spirituality interchangeably. In addition, in many instances, theology has been conceptualised as religion or spirituality. However, an in-depth clarification of these concepts is beyond the scope of this work. They are closely related, but slightly different. They are related in the sense that spirituality and theology can be based on a particular religion. However, spirituality does not necessarily derive from religion, especially the organised religions. Moreover, all religions are not primarily theocentric, and one should exercise caution when making broad definitions of religion.

Religion is difficult to define for the simple reason that there are "God-centred", "gods-centred" or "god-less" religions. The general concern of religion, however, is relation-building. This theory of embodied religion, which derives from the etymological possibilities of the word "religion", relates to the human sense of touch – tactility. David Chidester's reflection is apposite in this regard. He says:

> *If we give credence to etymology – and if we accept that religion has its roots in religare "to bind" (more literally re-bind) – then we have a tactile basis for the very notion of religion. From its ancient origins, according to this rendering, religion has been about binding relations, either among humans or between humans and gods, relations that have constitutional fabrics and textures, the links and connections, the contracts and covenants of religion. In this respect, although religious discourse might very well point beyond all that can be seen, heard, smelled, tasted, or touched, it points with a hand that is religiously bound. Tactility, in this view, is a fundamental bond of religion.* (10: p 75)

In its functional sense, religion makes "interesting statements about human beings" (11) in "an organized socio-cultural system". The tactility of spirituality is deeply at the core of "individuals' personal quests for meaning and fulfilment" (12, 13).

Spirituality is not necessarily related to religion. However, we know that both are closely related. Believing in God and belonging to a religious organisation are not necessarily the same. Some claim to believe and not belong, some claim to belong but not believe, and yet others believe and belong. Necessarily, however, even if belonging is not a precondition for spiritual experience in a broad sense, one cannot deny that it does a great deal to "facilitate the spiritual aspect of man or create a healthy lifestyle through particular mores" (1). In the words of Adrian Andreescu, the challenge is: "How can we bridge the divide between the consensual world of religiosity and the uniquely private world of spirituality, that relates to what might be viewed as the sacred?" (6). We must critically acknowledge this challenge and relate it to the substantive and functional distinctions between spirituality and religion. However, this question is beyond the scope of this article.

According to Gowri Anandarajah and Ellen Hight, "Spirituality is a complex and multidimensional part of the human experience. It has cognitive, experiential and behaviour aspects." (3) In its philosophical aspect, it seeks meaning, purpose and truth in life, as well as the beliefs and values that guide people's lives. The experiential and emotional aspects have to do with the feelings of hope, love, connection, inner peace, comfort and support. The behavioural dimension concerns the way people externally display their spiritual beliefs and inner spiritual state. Thomsen points out that spirituality can be viewed as "that part of a person's being that involves the intangible non-physical world. It is influenced by our core value systems, our psychological make-up, our religious beliefs, and our emotional sub-conscious memories." (9) According to Richardson, spirituality is related to the human quest for meaning and purpose in life which, in most cases, have "a transcendental perspective" (1). So, spirituality strives to cross the cognitive borders. This is important insofar as the relationship between medicine and spirituality is concerned.

The connection between spirituality and medical practice

From the above, it is clear that there is a relationship between spirituality and medical practice. This is so because both areas of human knowledge and experience are concerned with the wholeness of the human person. Spirituality can be both is theological and symbolic. The importance of a symbol cannot be overestimated, for it points to, and participates in, the power of the reality it represents. When Christians, Bible scholars and theologians go to a hospital and see a symbol of a serpent coiled around a pole, the story in Numbers 21: 6–9 readily comes to mind. This passage tells of how the Israelites murmured against God and Moses, demanding water and victuals better than manna. As a consequence of this, fiery serpents invaded the camp and bit the people. Moses prayed to God for mercy and he was commanded to make a brass serpent, which he erected on a pole. Whoever was bitten by the serpents and looked up at the brass serpent with faith survived, cured and healed. What is of spiritual import here is that it was only those who looked at the brass serpent with faith who were healed, despite the fact that all Israelites were believed to be chosen by God and bonded by a covenant. The hospital symbol is derived from this biblical story, and reflects the deep link between medicine and spirituality.

Corey Richardson lends a historical finesse to the symbolic–theological aspect outlined above. Speaking about the fact that every faith has developed its institutions for healing, he argues that the relationship between faith and healing goes back to "the foundation of the healing arts in early civilisations, and history has shown that all of medicine developed within the context of religion". The literature available demonstrates that spiritual healing has been practised by every known culture. The shamans, for example, use techniques involving dreams and trances to cure their patients, and to guard the soul of the community. As for the early Greek and Egyptian civilisations, there is ample evidence of how hands were laid on the sick to heal them, a practice which later became popular among Christians. In the early Christian era, "physicians were clergy members, and the Church was the first to grant medical licenses" (1).

In the case of traditional Nigeria (Africa), missionaries and colonialists worked together to balkanise and discredit autochthonous therapeutic practices, which were considered ineffective and satanic. This was the result of a complete ignorance of the healing methods and rituals employed by the traditional Africans, and the missionaries' and colonialists' extreme sense of superiority and hubris. There are obvious differences between traditional medicine and magical practices. Even the African converts were unable to tell the two apart, and believed that almost everything traditional

and African was satanic. This mentality gave rise to what Miles calls the "national inferiority complex" (14). While the colonialists encroached into the missionaries' field and tried to separate church from politics, where and when profitable and convenient, Christianity lapsed into syncretism with African traditional religious healing practices. The African Initiated and Pentecostal churches represent this historical trend (15). Keith Warrington argues that in the beginning, the Pentecostals drew a line between medical and divine healing, assuming the former to be an unacceptable and inadequate form of healing. However, the differences were bridged further down the line through an acknowledgement that medicine and the natural curative properties of the body depict the work of a creative God. So, the Pentecostals began to teach about health and healing (16). Richardson further argues that the relationship between the Pentecostals and traditional religious healing practices was severed as faith and the practice of "healing diverged with the advent of the Scientific Method". As a consequence, medicine became largely "a purely mechanistic model" (1).

Citing Levin and Schiller, Felix Oluwatelure reports that the scientific study of the effects of religion on health has been carried out since the past 150 years. Such scientific study has focused on particular aspects of the medical situation. For example, Levin and Schiller found that of about two hundred and fifty studies on the effects of religion on health, about 48 were specifically on cardiovascular disorders, with most of the latter being on hypertension (17). Levin and Vanderpool hypothesised that religion generally fosters behaviours that promote healthy living through dietary and psychosocial prohibitions, with particular reference to hypertension. They said:

> *Because religious practices pervade human society, and because hypertension is a common and serious problem, which appears to be mitigated by religion, the question of whether characteristics or functions of religion can indeed lower high blood pressure is both scientifically and clinically intriguing (fascinating or interesting).* (18)

About two decades ago, Engel (19) expanded the biomedical model to include psychosocial factors. He emphasised the significance of recognising and attending to these factors when providing medical care. Since his work in 1980, there has been renewed interest in the bio-psychosocial model of medicine, which is accepted and widely taught in several medical schools today. In 1986, Hiatt (20) proposed expanding the accepted bio-psychosocial model to include spiritual factors, and Kuhn (21) seconded this in 1988. Richardson observes that not only have more than 1200 scientific studies been published on the relation between spirituality and religion in the context of health and healing, conferences on this subject have been held regularly, at both the local and international levels (1). Efforts at integrating spirituality into medical practice through colloquia, such as Spiritual Dimensions in Clinical Research, have gained considerable momentum (1). Anandarajah and Hight report that about "50 medical schools currently offer courses in spirituality and medicine" (3). This suggests that the relationship between spirituality and medicine is real and expanding.

The most critical obstacle in the way of the relationship between spirituality and medical practice is the argument for the separation of spiritual and medical rationalities. This is a product of the pattern of thought spawned during the Enlightenment, though with political undertones. Laboratories in North America and Europe are viewed as modern secular realms which excise the spirit so that true scientific work may proceed. In this purely scientific environment, a hospice with religious or spiritual symbols and paraphernalia meant to stimulate religious sentiment is out of place. The popular culture of rituals, believed to ameliorate the state of the sick, is considered unscientific because there is no way of demonstrating *how* the connection works. William Sax argues that "ritual is precisely the *negation* of the modern, scientific episteme, which is one of the things that make it such an interesting category" (22). This is so because ritual belongs to the analytical rather than the essentialist category. Howard Brody opines that western conventional medicine subscribes only to scientific knowledge. As a result, medical practitioners can promptly deny the efficacy of rituals in medical science (23). In this extremely secular space, seeking the favour of God is an apodictic demonstration of "the inability of 'third world' biologists to purify their labs of spirit" (24).

In response, Elizabeth Roberts observes in the context of Ecuadorian *in vitro* fertilisation (IVF) clinicians and laboratory biologists that the "spiritual approach to laboratory rationality does not trouble these IVF practitioners' experience of themselves as modern", but rather, "they are comfortable combining the domains of spirit and matter in the realm of science" (24). They believe that spiritual connection or the invocation of the divine helps to mitigate the uncertainty that surrounds IVF. This provides an explanation for the presence of religious emblems in their laboratories and the practice of constant prayers (24) She suggests that rather than sticking to the argument that science, particularly medicine, should remain uninfluenced by spiritual forces and should consign spirituality to the dustbin of "pre-modern irrationality" (24), the focus should be on the form which the relationship should assume in the light of global experience. Sadegh-Zadeh's argument in this context is apposite: "It is shown that rationality cannot be a criterion of the scientificity of medicine, because rationality is something relative, and depends on the perspective from which it is judged" (4:p7)

Forms of spiritual intervention in medical practice

It is worth noting that alternative therapies have come to be accepted, just as conventional treatments. Although the reasons for which many prefer alternative therapies might range from medical to economic, the point is that these therapies are based on intuitive reasoning. Intuition, as we know, appeals to spirituality for guidance, validation and credibility. The relation between alternative therapies and

spirituality may be so strong that rejecting one may imply rejecting the other. Conventional medical practitioners claim to be science-oriented or science-based and, therefore, reject alternative therapies, as though they alone have a claim to spirituality. Thomsen opposes this and avers that "spirituality is as much the provence of science-based medicine as any other area" (9).

What is required is the cultivation of spirituality by medical practitioners for themselves, for their patients and with their patients. Patients, too, need to engage themselves in this endeavour. Thomsen suggests that physicians should cultivate an appropriate spiritual attitude. The spiritual journey is tedious, and requires steady devotion, study, prayer, meditation, worship and a community. As for "study", physicians need to carefully select religious materials that have stood the test of time, eg the Bible. "For their patients" signifies that they need to pray for their patients, while "with their patients" (9) entails a knowledge of the patients' religious beliefs and affiliations, so that they can build friendship and trust. Jim Gagne puts forward the approach of "FICA: **F**aith/belief; **I**mportance to you; to which spiritual **C**ommunity do you belong; and how would you like the physician to **A**ddress or include your beliefs?"(25). The purpose of such approaches is to respect a patient's spiritual perspective or faith within the context of traditional medical practice (25). Levin and Vanderpool suggest that religious affiliation, church membership, religious attendance, the status of clergy, religious education and membership of monastic order are measures of the religious impact on the relationship between physicians and patients and the health of the latter (18).

One of the most comprehensive approaches is that of Anandarajah and Hight. This includes both informal and formal spiritual assessment. At the informal level, the physician should keep an open mind and listen carefully to the stories that patients tell regarding their lives and illness, and should then interpret the spiritual issues involved. Issues such as the quest for meaning, and feelings of connection versus isolation and hope versus hopelessness, which express the patient's spiritual beliefs, provide a glimpse of what the patient needs. At the formal level, physicians conduct a medical interview during which they ask patients specific questions, ie HOPE questions, to ascertain whether or not spiritual factors play any role in the patient's illness or recovery, and whether such factors affect the medical treatment plan (3). Below are examples of the HOPE questions:

"Sources of hope, meaning, comfort, strength, peace, love and connection

We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?

What are your sources of hope, strength, comfort and peace?

Organised religion

Do you consider yourself part of an organized religion?

How important is this to you?

What aspects of your religion are helpful and not so helpful to you?

Personal spirituality/ practices

Do you have personal spiritual beliefs that are independent of organized religion? What are they?

Do you believe in God? What kind of relationship do you have with God?

Effects on medical care and end-of-life issues

Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?)

As a doctor, is there anything that I can do to help you access the resources that usually help you?" (3).

C. Kuhn's inventory, which includes 25 sets of questions that are administered for clinical use, is also widely accepted. Dr Kuhn adds many different facets of a patient's life in the questionnaire, which also reflects a more complete perspective of spirituality and its effect on one's existence. The inventory sees a patient with spiritual health as one who believes that there is meaning and purpose to life's events, including illness; has hope, faith and a relative absence of guilt; is able to love and forgive himself/herself as well as others; can laugh readily and participates in celebrations; and is involved in a community of faith and practises worship, prayer and meditation (21).

As a rule, physicians ought to respect their patients' beliefs when obtaining information on their religious or ideological orientation and beliefs. They ought to be empathetic to the patient's attitudes and sensibilities. Physicians ought not to impose their own religious, anti-religious or ideological systems of beliefs or rituals on accepted diagnostic concepts or therapeutic practice. Nor should they use the process of questioning as a means of proselytising because this may prove counterproductive. Other than simply identifying socioeconomic factors and demographics, physicians ought to respect their patients' values and life experiences, while learning from them and allowing themselves to be enriched by the process. When the process is carried out in a sensitive and inclusive manner, it can help to develop a patient's spiritual health; the physician is promoting trust, a sense of well-being, response to the therapy and an overall improvement in health. However, time and patience are needed for physicians to achieve the intended goal (1).

Brody argues that empathy should be taken further. According to him, if physicians understood that medical spirituality or rituals in medicine have a potential healing force or power, and that their ability to take part in the rituals in an optimal way might result in positive health outcomes, then they might be willing to utilise such rituals to the best of their ability. "What does it mean, for instance, for the physician and

patient to become jointly involved in a healing ritual, in an ideally empathetic way?" This form of the physician–patient relationship is important for the medical practice. It is a truism that medicine would lose a lot of its efficacy if it neglected all spiritual/ritual elements and practices (23: p 164).

Prayer as a tool in medical spirituality

The role of prayer in spirituality and particularly, in relation to health cannot be overemphasised. Most of those who have conducted research into medical spirituality confirm that prayer, indeed, helps to restore the health of the sick. Herbert Benson has experimentally demonstrated that prayer has a positive influence on the sick (26, 27). But what is prayer? Prayer is thought of as a communion or conversation with God, in which the petitioners bare their mind to God. It involves listening carefully because, as a conversation, it must be two-way: the petitioners talk to God and listen to God's response. However, all forms of prayer are not applicable to the medical setting. One form that is often utilised in the medical setting is the intercessory prayer, which is praying to God on behalf of the sick. Although this seems to be common, it requires a great deal of faith, discipline and honesty on the part of the petitioner.

Different religious traditions emphasise different aspects of prayer. For example, Deborah Cassidi, Ruth Burrows, and Jordan Aumann (28–30), being Catholics, believe that praying is not what man or woman does for God; rather, it is essentially what God does, and how God addresses and looks at man and woman. For the Pentecostals, prayer is central to their theology and spirituality, and an act of active communication with God (16).

Andreescu argues that prayer as an act of communicating with the divine is "the most remarkable culturally-mediated form of normative dissociation and a ubiquitous religious phenomenon". As such, it is used as a means of building a virile and personal relationship with God. Therefore, "investigating prayer's place within the process through which supernatural order is known and experienced by believers could offer a glimpse into the trained absorption skills shared by those lay people manifesting significant spiritual and transpersonal experiences" (6:p25). It has been suggested that one way of doing this is for medical practitioners to personally "develop a prayer life" on their own. Luhrmann, Nusbaum and Thisted hypothesise that a personal experience of God is a precondition for developing a prayer life. This experience depends on the interpretation of sociocultural thought and cognitive categories that recognise the presence of God; practice, which encompasses the subjective and psychological consequences of specified religious training, as in prayer; and proclivity, which has to do with talent and response to practice (31).

It is believed that the practice of dissociation is necessary for prayer to be meaningful and effective in a hospice. Patients are required to dissociate themselves from their present health condition, and "against objective medical proofs", while hoping for and living with a deep conviction that they are undergoing "an active healing process". Faith is essential to healing obviously because the "production of healing" through prayer may fundamentally depend on and be enhanced by one's ability to transcend the dense rational and emotional ceiling derived from and enforced by the normative cultural patterns of secular societies. In Christian theological parlance, a "prayer-based approach is necessarily based on the presumption that God, however understood, will always grant some form of healing to any believer who expresses in his or her identity and spiritual practice a stable constellation of elements" (6: pp 28–31).

Gagne argues that prayer or spirituality is "a potent healing force", especially in relieving suffering or in illnesses the symptoms of which are worsened by stress or fear (25). According to Jeff Levin, lack of religious ritual, eg prayer, is a risk for in a medical condition, and no research has shown that religious involvement negatively affects health. Rather, he finds that "people who are spiritually fit and religiously active live longer and healthier lives, recover more quickly from illness, and cope better with disability and terminal disease" (32). Anandarajah and Hight, through HOPE questions, have obtained uncanny results with respect to the effects of prayer on health. There is increasing evidence in the medical literature of a strong relationship between spirituality and medicine in the West (3). DD McKee and JN Chappel argue that spiritual issues surrounding medical practice are real, and the results of the relationship are amazing (33).

Challenges and recommendations

Notwithstanding the positive results with respect to the influence of prayer and spirituality in general on the sick, the relationship between spirituality and medicine continues to be assailed by certain challenges. While medical science evaluates current evidence on the basis of empirical tools, spirituality cannot be subjected to these tools. As Andreescu puts it, even if "healing cancer is a matter of the extraordinary", medical science wants to know and evaluate the "extraordinary" (6). Richardson sees the challenges to the relationship between spirituality and medicine as credible, but surmountable. According to him, physicians may neglect prayer or spiritual attention because of personal discomfort, fear of imposing their religious or spiritual opinions on their patients, lack of knowledge of the recent scientific findings in this area, or their personal opinion, based in academia, that medicine is a pure science that excludes spirituality (1). These challenges are a consequence of the past failure of medical and social science research to provide the academic community "the clinically significant results that would have supported beyond doubt the idea that prayer can improve… in a relatively predictable manner… the health outcome" of the patient (6: pp 28–32).

Rather than dismissing the efficacy of prayer in healing the sick, physicians should now take up the challenge of engaging in a persistent, stimulating and unsettling search for new forms of theorising on the issue (34). This complex task requires new

methods of study, characterised by an honest desire to search, coupled with an open-minded approach. It must, however, be kept in mind that there are things which human beings cannot fully understand. Oluwatelure holds that miraculous healing is difficult to evaluate through scientific methods because their operations are guided by different laws. Spiritual law derives from divine power. Since divine power is higher than natural laws, which medicine and science generally depend on, miraculous/spiritual processes are beyond the scope of scientific mechanisms and the latter may not be able to successfully penetrate the workings of the former, at least for the present (17:p31).

In the light of the above, we suggest the following.

1. Physicians should "begin the process of integrating spirituality into medical practice, it is important to keep in mind the advice to "do no harm" and to maintain the utmost respect for the patient's rights to autonomy and freedom of thought and belief. If done responsibly, the practice of medicine may be the best arena for integrating science and spirituality. The future exploration of this field offers physicians the opportunity to improve care and gain a clearer understanding of some of life's and medicine's greatest mysteries" (3).
2. Physicians should develop their knowledge of spirituality (prayer) and health issues and integrate prayer into the mainstream paradigms of future academic endeavours (as such knowledge might be currently beyond scientific understanding – not by definition, but by virtue of the fact that it is still at the frontier of that understanding). This will offer a deeper understanding of the study of prayer-mediated healing and what it means to be human.
3. Physicians should review the practice of medicine that places limits on the patient–doctor interaction. The logic underlying it is that of managed care. Medicine has been re-conceptualised to be similar to any other industry. While scientific reductionism depersonalises medicine from the inside, managed care has reduced medicine from the outside, with programmed interaction, an increasing number of forms and red tape, etc., which do not allow for spiritual discussion with patients.
4. Without compromising medical integrity, physicians should be humble enough to accept the fact that there are limits beyond which medical knowledge cannot go. This is the area of the spiritual. Similarly, true spirituality should not despise medical practice.

Conclusion

Modern medical knowledge may be somewhat exclusive to trained physicians, and may not be in the realm of everyone who wishes to acquire it. The same goes for spiritual knowledge. However, it is not unusual to come across spiritual or church/mosque leaders studying (no matter how peripherally) medicine, not for the sake of practice but as a basis for their spiritual ministration. In fact, on many occasions, psychotherapy sessions are held for some people before prayers are administered. It is also not uncommon to find a revered physician being a spiritual leader in his/her religious organisation. These physicians balance their medical knowledge and integrity, on the one hand, with their spiritual experience and application, on the other, utilising both for the wholeness of their patients. This approach can be very helpful to patients in terms of speeding up their recovery, and at the same time, can give greater satisfaction to physicians, making them more whole and integrated in body, mind and spirit.

Everyone has his/her peculiar cultural and moral context and religious landscape. Given the universality of this fact, there is a need to re-examine the long-standing official assumptions about the automatic separation of spiritual/religious and material rationalities in the scientific milieu. The implication is that physicians can be modern (or scientific), and yet meet the spiritual or existential need of their patients. However, they must also humbly and honestly accept the fact that there are occasions on which neither orthodox nor spiritual power is able to "cure", "heal" or "deliver" the sick. The "mystery", though not within the scope of this work, lies within the broad spectrum of some uncertainty principle: we cannot be certain about everything, at least for now.

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Ethical dilemmas experienced by clinical psychology trainee therapists

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Abstract

Ethical dilemmas are inevitable during psychotherapeutic interactions, and these complexities and challenges may be magnified during the training phase. The experience of ethical dilemmas in the arena of therapy and the methods of resolving these dilemmas were examined among 35 clinical psychologists in training, through an anonymous and confidential online survey. The trainees' responses to four open-ended questions on any one ethical dilemma encountered during therapy were analysed, using thematic content analysis. The results highlighted that the salient ethical dilemmas related to confidentiality and boundary issues. The trainees also raised ethical questions regarding therapist competence, the beneficence and non-maleficence of therapeutic actions, and client autonomy. Fifty-seven per cent of the trainees reported that the dilemmas were resolved adequately, the prominent methods of resolution being supervision or consultation and guidance from professional ethical guidelines. The trainees felt that the professional codes had certain limitations as far as the effective resolution of ethical dilemmas was concerned. The findings indicate the need to strengthen training and supervision methodologies and professional ethics codes for psychotherapists and counsellors in India.

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Introduction

At different stages of their professional journey, therapists are inevitably confronted and troubled by choices between "right versus wrong" and "right versus right" (1). Intrinsic to therapeutic interactions are the negotiation of the balance between the "person" of the therapist and his/her professional role, the fact that the therapist–client encounter takes place in a private space, and the inherent power imbalance between the therapist and client. All these contribute to the emergence of ethical dilemmas. Ethical dilemmas are ubiquitous in therapy (2) and represent the experience of an apparent conflict between alternatives, neither of which is completely acceptable. The choice of any one action inevitably results in some ethical principle being compromised.

Trainee therapists grapple with the complexities and challenges of shifting from the known role of the lay helper to the unknown role of the professional (3). The anxiety of trainee therapists, meeting clients and supervisors for the first time (4,5), makes them particularly vulnerable to a range of difficulties. Findings from the International Study of the Development of Psychotherapists (6) indicate that inexperienced therapists experience more challenges than do practitioners at later stages of professional development. These challenges include feeling troubled by moral or ethical issues during interactions with clients.

Ethical issues are often complex, multifaceted, and do not always have unambiguous answers (7). Professional ethical guidelines tend to vary in the degree of detail and are