

Spiritual interventions

I don't think people should be blamed for being sick, or blame themselves for creating their sickness. But the cost of stripping illness of meaning is too high. We demean our own experience. You want to take the moralizing out of the meaning, but if you don't search for meaning, you don't become your own authority.

Gerald Epstein¹

John was a man in his mid-fifties who had been very successful in life. He had gone through a series of prestigious careers and had consistently found himself in leadership positions. He presented to his family physician with both severe heartburn and high blood pressure. Initial treatment plans involved ranitidine for the heartburn and instructions to monitor his blood pressure and lose weight. As the relationship between the physician and John developed, he began to reveal that he had experienced a long-term struggle with addictive behavior, using a variety of 'medications' including sex, alcohol, and work. He noted that he often played a 'tape' in his head, replaying moments in which he had behaved shamefully. He noted that it was a vicious cycle. He would remember a behavior of which he was ashamed, and as a result of the feelings that engendered, he would seek to medicate. That medicating behavior often involved a new episode of which he was ashamed, adding to the library of mental tapes. He seemed to be in a pattern that trapped him and created a great deal of spiritual distress. Eventually the physician offered John a couple of options. One option was to develop a 'ritual of release.' Since John did believe in a forgiving God, each time he recalled something he believed needed forgiveness, he was to write it down, as an act of confession, and offer it to God. He could destroy the note in whatever manner he chose. The other option was to connect with a 12-step program and learn from a sponsor there how to use 'amends' as a healing tool. John chose the first option, and eventually, because of a close Roman Catholic friend, began to confess weekly to a local Roman Catholic priest. Eventually his feelings of guilt and distress began to dissipate and he found it easier to avoid destructive and hurtful behaviors.

This creative intervention addressed the spiritual condition of the patient, and the intervention, which was primarily a matter of finding options and supporting action choices, had a positive impact on both the patient's dis-ease and disease. Because the clinician was able to identify a critical spiritual issue and facilitated an intervention, the patient was able to address his guilt and decrease his physical symptoms.

Once information has been gathered and a spiritual assessment has been made, what then? We have identified a set of core objectives for the integration of medicine and spirituality. Now it is time to explore some strategies for accomplishing these objectives. What kind of interventions will help patients achieve self-awareness, explore their spiritual frameworks, and identify creative options? How far can we go, considering the amount of time available? What level of care is possible considering the spiritual and/or counseling expertise of the clinician?

Preparing for intervention

Understanding levels of intervention

The clinician can, at least to some degree, function as a counselor. This is not a concept that is foreign to many physicians who are often placed in that position by patients. Patients will frequently bring up such issues as marital stress, addiction problems, depression, anxiety, and ethical dilemmas. In one small rural community a family physician was even asked to advise a family on what college their child should attend. The question is not so much *if* the clinician should function as a type of counselor, but *at what level*?

First we must ask what we mean by the term 'counseling.' This task can potentially include a wide range of activities. It has been suggested that counseling can involve three basic functions or levels.² The first function is what might be called active listening. At this level the clinician uses basic listening skills to help the patient express their feelings and disclose their issues. Also, through empathic listening, the clinician is able to show compassion and express empathy. The second function is that of offering counsel. At this level clinicians take a slightly more active role by interacting with free information offered by the patient. At this level the practitioner may amplify information given by the patient, adding new, perhaps critical, knowledge. They can challenge patients by helping them see distortions, generalizations, and deletions. They can help patients to see their 'life rules' and aid in the process of affirming, adjusting, or abandoning those rules. The third function is that of psychotherapy. Psychotherapy differs from counseling in its nature, intensity, and duration. With psychotherapy the professional relationship is primarily focused on the task of removing, modifying, and decreasing symptoms related to an emotional disturbance or mental illness. In general a lack of time and training precludes most physicians from functioning at this level. However, the first two levels, those of active listening and providing counsel, are both appropriate and possible within the usual context of the healthcare setting.

Limitations

There are, clearly, limits to what the healthcare provider can offer in either the inpatient or outpatient setting. If we return to the concerns listed earlier by primary care physicians,³ we can easily understand what some of those limits are. First, there is the issue of time. The fact that many clinical encounters are being forced into a short time frame, as little as 15 minutes, makes it difficult for the physician to interact with the patient around spiritual matters. The biomedical imperative of the

visit is dominant and can preclude other issues from being discussed. However, in many cases issues do emerge, and studies have shown that addressing those issues can actually assist the biomedical agenda. A study of 116 routine office visits found that in over half of the clinical encounters the patients offered clues about issues that were troubling them. In 60% of those cases the issues were emotional in nature. If the physician picked up the clue and responded to it in a meaningful manner, the time spent with the patient tended to be shorter than when the clue was ignored.⁴ If a person feels strongly enough about an issue to reveal it, even indirectly, then it may be important enough to pull the focus away from other agendas. By hearing the clue and responding to it, the clinician may free the patient to focus on the biomedical agenda. The lack of time available does not affect whether or not spiritual issues *should* be addressed, but it does impact the degree to which it *can* be addressed. Time constraints may keep the intervention to the levels of active listening and offering counsel.

Another key limitation is the lack of training received by physicians with respect to emotional or spiritual problems. Over the past 10 years, a significant number of medical schools have begun to include the topic of medicine and spirituality in their curriculum, both as elective and required elements.⁵ In spite of this, most physicians have only minimal training in the art of integrating spirituality and medicine. First, this movement is relatively new, so physicians who graduated from medical school before 1995 are unlikely to have had any training at all. Second, many such courses provide students with the rationale for integration and information about major religious groups, but do not truly provide the students with the basic skills necessary to effect integration (such as active listening skills). Third, the level of training rarely enables physicians to engage in long-term, in-depth therapy. Clinicians can help with awareness and reflection, but often are not prepared to move deeply into the issue.

This combination of minimal time and negligible training means that the primary role of the physician is that of catalyst. In the clinical encounter physicians can bring spiritual issues or needs to the awareness of patients, and begin the process of helping the patients explore and resolve these issues. But ultimately resolution will come only as the process of healing continues outside the clinical context. Patients will need to use their new awareness and knowledge as a starting point for serious spiritual work. In some cases, this work may be done by the individuals themselves, through activities such as prayer, reading, or meditation. In other cases, spiritual experts can become involved in the process. Chaplains, spiritual leaders, and psychotherapists can work with the patients to help them continue the process of spiritual recovery. This does not mean that the role of the physician or nurse is unimportant. People faced with illness or death, people engaged in an environment that is strange and frightening are uniquely vulnerable. This vulnerability is both a danger and an opportunity. The danger is that patients will disintegrate in the face of such challenges. The opportunity is that the very presence of disease and dis-ease can generate openness, change, and growth. The physician can be a catalyst for growth.

Prerequisites

Before a clinician can begin to integrate spirituality into the healthcare context and introduce any sort of intervention, there are a number of prerequisites that are important to observe. The first prerequisite is for the clinician to have a clear understanding of his or her own spiritual beliefs and world view. What we believe and the values we hold, have a significant impact on how we respond to people and events.

Peter was a young physician who joined a practice in a small rural community in eastern Washington. He truly enjoyed the small farming community and its people and found his practice rewarding. However, there was one patient he could not stand. Mel was a 69-year-old wheat farmer. He was suffering from emphysema due to a lifetime of smoking. In spite of his smoking, which he called his 'major vice,' Mel was a very religious man. He belonged to a small independent church nestled among the wheat fields about 4 miles from town. During his clinical exams Mel often sprinkled his responses with religious phrases. He talked about being 'washed in the blood of the lamb' and about the 'redeemed life.' He often made negative statements about what he considered 'unchristian' behavior. He was very confident in his own faith, and noted that when he died he'd be 'dancing on streets of gold.' Mel's illness had him close to death. Although he was coping with his situation admirably and was a compliant patient, Peter found himself repelled by Mel. His sessions with Mel were often brief and were relationally cold. Mel clearly sensed this, and after about 6 months, transferred to another clinic about 40 miles away.

When Mel died, Peter attended the funeral. It was as he sat in that small church that he suddenly realized what had happened. Peter had been raised in a church very much like Mel's. When he was in grade school his mother, who was single, had become sexually active with a man. The church leaders had discovered this and had called his mother before the congregation. They rebuked her and forced her into an emotional confession of her sin, and expelled her from the fellowship. Peter had been very angry over this treatment. His mother, who eventually married her lover, simply changed churches, and became active in a small Methodist church. Peter had vowed never to attend church again, and had been as good as his word. Sitting at that funeral he realized that he had projected his anger at that childhood church on to Mel, whose words had reminded him of that church.

We must understand our own spiritual, religious, and cultural filters. In this way we can better understand our responses to those we work with and ensure that they are healthy and appropriate. The Family Practice Residency Program at Oregon Health and Science University in Portland, Oregon, includes a curriculum on the integration of medicine and spirituality. As part of that curriculum faculty members encourage young physicians to explore their own spirituality by using the journey model. They ask the learners to think back on their spiritual history. What were some of the key moments along the way? What impact did these key moments have? How did they affect the journey? The educational goal is to help the learners understand where they are at this point in their own journeys. Students have illustrated their journeys in many ways. Some have drawn spiritual 'maps,' others have

brought in pictures illustrating key moments in the journey, or written a narrative. For many of them it has been the first time, or the first time in many years, that they have thought about their spiritual life and journey. The exercise not only helps them explore the past, but it helps them begin to define their hopes for the future. Clinicians can also use one of the spiritual assessment tools that are available. The strategy for gaining self-awareness is not critical, but the act of gaining that awareness is.

Second, it is important for any person using spiritual interventions to have some degree of spiritual accountability. One physician in Portland uses her local rabbi as a spiritual supervisor or consultant. In the context of this relationship she explores spiritual issues and examines her own responses. Groups can also serve this purpose. Balint or professional support groups, for example, allow clinicians the opportunity to explore the psychological or spiritual aspects of their patients' problems – and reflect upon the way they are interacting with their patients.⁶ Supervision or study groups, in which the spiritual issues that come to light through the therapeutic alliance can be further explored, have been recommended by Fukuyama and Sevig,⁷ experts in the integration of spirituality and counseling.

Ideally, those who would address spiritual issues in practice should be people who are actively involved in their own spiritual journey. As one guide on spirituality and counseling notes:

Counselors should be actively engaged in their own spiritual journey, one that includes practices congruent with the counselor's chosen spiritual path. In helping a client along his or her spiritual journey there is no substitute for personal experience.⁸

There is no demand that the clinician be 'religious' or even that they participate in a well-defined spiritual system. The clinician simply needs to be a person who is aware of the spiritual aspect of his or her personhood, and is actively seeking to nurture that part of the self. It would be very difficult for a person who denied the spiritual facet of the person, or avoided or repressed that aspect of the self, to work with others around spiritual issues.

Categories of interventions

It is possible to categorize interventions in many different ways. The preferred approach is to use the objective of the intervention to determine the category. The objectives, which we defined in Chapter 8, provide an excellent framework as they are progressive in nature and pull us toward our ultimate goal of healing. Early in the process, for example, we are trying to create awareness. Therefore we want to develop strategies that produce this desired result. Later, we might want to the patient to think about the beliefs and values they have disclosed. For this activity we need a different category of interventions: those that challenge the status quo and encourage critical reflection. Using this approach we can define the following categories.

Empathic strategies – creating trust
Gathering information/assessing – creating awareness
Challenging/reflecting – stimulating change
Facilitating spiritual movement – facilitating change
Collaborative strategies – facilitating change

As we develop strategies appropriate for each of these categories or stages, it is critical that we be aware of several other factors. These additional factors help us expand our thinking and become more creative and inclusive in our approaches.

First, as we choose to work with patients on spiritual issues we are not ultimately limited by the clinical setting or by our training and experience. It is possible to supplement what happens in a session with interventions that take place outside of the clinical setting. We can provide our patients with 'homework' or 'soul work,' prescribing activities they can do between clinical sessions. Those activities might include specific religious activities, such as worship, prayer, the reading of sacred writings from the person's faith system, or participation in sacraments or rituals. They might include more universal or esoteric exercises such as meditation, walking meditation, or reading from writings that are not aligned with a specific religion.

We can also augment our efforts by referring patients to spiritual resources that can aid them in their efforts to become whole. Those resources can be in the form of spiritual specialists, such as a religious leader or spiritual counselor, or they can be in the form of groups, such as 12-step groups, support groups, or study groups. Using such resources greatly enhances the limited training and experience of the healthcare professional. Such collaboration is critically important for the integration of spirituality and medicine, for without collaboration, the ability to impact patients spiritually is severely limited.

The use of spiritual interventions

We have already discussed the various levels of counseling, ranging from listening to psychotherapy. The interventions that are possible within the healthcare context will involve all three levels. The first two levels, active listening and providing counsel, are likely to take place in the healthcare setting itself and be implemented by the clinicians themselves. The third level, psychotherapy or formal spiritual counseling, is more likely to take place outside the clinical setting and be provided by spiritual experts or mental health professionals. These interventions will be the result of a referral by the healthcare professional, and, ideally, will be collaborative in nature.

Interventions to create trust

The first prerequisite of the effective integration of medicine and spirituality is the development of a safe environment. So many patients have no one they really trust. Such people have no relationship that provides them with a sense of security and comfort. The therapeutic relationship can become such a relationship. The physician, nurse, or social worker can help a patient feel cared for, valued, and safe. They can provide a context where the patient feels free to share his or her deepest thoughts and feelings. Thus, initial interventions must focus on creating that 'free and friendly space' where spiritual healing can occur.

The most basic of these interventions is what we have called *active listening* (Chapter 7). Listening is an act of love. By truly allowing the patient to say what they need and desire to say, but using techniques that allow them to maintain control of

the conversation's agenda, we show that we care and that we value the thoughts feelings and perceptions of the other.

Empathy is also conveyed by the messages we send. It is conveyed first through body language: through eye contact, touch, by simply leaning forward. It is conveyed when we share, directly and clearly, our own internal state. When we have empathy our feelings mirror those of the person we listen to. What they are feeling at a deep level grabs us, and creates a similar feeling in us. This is why it is important, as one professor at a Princeton Seminary once said, to 'trust your tummies.'

Neil was a first-year Family Medicine resident. He was in the middle of an obstetrical rotation when he was present at a spontaneous abortion. Plans were being made by the medical staff to autopsy the child and then dispose of the body. While talking to the mother he began to get a sense of deep anguish. He said to the young mother, who was numbly agreeing to the instructions of the surgeon in charge of the case, 'As I listen to you I feel a sense of real anguish. Is this how you feel too?' At this the young woman broke down. It turned out that in her faith system it was deemed very important for even a fetus to be given a 'Christian' service and be buried with the family. This related to the group's beliefs about resurrection of the body. It was very important to her to take her baby home, a need the obstetrical staff was ignoring.

Because Neil was able to experience genuine empathy, and was able to express that empathy through a direct expression of feeling, he was able to help a young woman share a critical spiritual issue.

With empathy we take what Lewis Walker calls the 'second position.' When we take this position, we imagine that we are in the other person shoes, 'feeling their feelings and thinking their thoughts.'⁹ Walker suggests we use *I-You* statements to present the thoughts and feelings that arise when we take this unique perspective. We say in effect, 'I sense how it has been for *You*.' It is important to note that when we share what we believe is their perspective, that we must do so in a tentative manner. As has been noted before, we cannot truly know their perspective. We can only guess. But it is appropriate to guess, as long as it involves an authentic effort to feel with the other person, and as long as we 'check' that perception. It is important then that any *I-You* statement include a check to make sure we have been reasonably accurate.

Empathy is the starting point for any spiritual intervention. It should also be the ending point. That is why the BATHE technique (Chapter 6) ends with an E for empathy. Once people have been open and have disclosed critical issues and feelings, it is important that they be assured that they have not only been heard, but heard with respect and compassion.

Interventions to gather information and create awareness

The act of gathering information is a necessary precursor to intervention, but such activities are also truly interventions in themselves. Many people have significant

gaps in their self-awareness that involve powerful issues and feelings. The process of listening to others, and thinking critically about what they say, is one way to help them fill in those gaps: to bring what was hidden within to the surface, where it can be dealt with.

The process of gathering information involves, again, active listening. By using skills such as paraphrasing, perception checks, creative questions, and negative inquiry, we not only come to understand the patient, but we help that patient come to self-understanding. It is not unusual for a patient, who has been helped by the use of good listening skills to share more deeply, to suddenly arrive at self-understanding.

Bob came into his clinic suffering from severe neck pain. He was sure he had simply strained a muscle, and was looking for a muscle relaxant. As he and his physician discussed what was going on in this life, Bob's body language was extremely suggestive. He talked loudly and quickly, his face was tense, and he often clenched his fists. In addition, he made numerous negative remarks about his job. The physician, wanting to explore all possible factors contributing to Bob's condition, asked him if there were any stressors in his life.

Bob quickly answered in the negative. 'No! Things are fine.'

'I was just wondering,' the physician replied 'I couldn't help but notice that your voice has been rather loud, and you have been clenching your fists. [Behavior description] When I act that way it usually means I'm angry.'

Before the physician could even check his observations, Bob responded: 'Wow, I hadn't really thought about it, but you are right. I am really angry. I worked incredibly hard to get a project going at work. I go on a business trip for a couple days, and I find they've changed the project. Then I go to a planning meeting and find they cancelled the meeting, and didn't even bother to tell me. I can't believe they did that!'

Eventually the physician and Bob came to the conclusion that his neck pain had its genesis in the stress he was feeling at work. He was feeling threatened, vulnerable, unappreciated, and, above all, angry. Once he was able to identify his feelings he was able to respond to them in an effective manner. A spiritual person, he chose to see the situation as an opportunity to reassess his life and look for new directions. An outstanding program developer, he moved from his job with a large corporation and began work for a newly formed non-profit. His neck pain went away.

The process of gathering information and enabling awareness can also involve a number of strategies that are not contained within the clinical setting. As part of the process patients can be given 'homework': exercises or tasks which they do on their own. The results of these activities then become the focus of a later clinical session. One such tool is the development of spectrums such as those described in Chapter 7. The process is relatively simple. The patient is asked to think about their spiritual life and identify five to eight themes that they believe are important. These themes can be either positive or negative. Negative qualities are to be written on the left side of a piece of paper, and positive on the right. They are then to find a word that describes the opposite end of the spectrum, and write that one on the other side of

the paper from the original word. The result is a set of polarities or spectrums. When these polarities are brought back at the next visit the patient has the opportunity to place themselves on each spectrum. This is a variant use of the spiritual spectrum discussed previously and has outstanding possibilities. The following is a set of spectrums, complete with commentary, that was brought in by one patient.

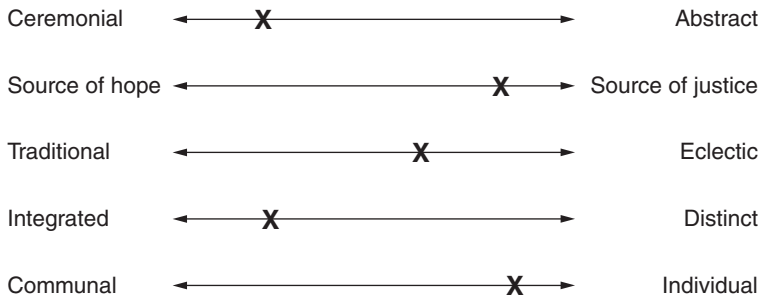


Figure 9.1

This particular patient not only created the spectrums, but added the following commentary to explain her choices.

- **Ceremonial/abstract:** The degree to which the person's spirituality is expressed in rituals.
- **Source of hope/source of justice:** The degree to which a person's spirituality offers hope or unwavering justice. A person whose spirituality is centered on hope, meaningfulness, and forgiveness is likely to construe their illness and its prognosis in a very different light than will a person whose spirituality is based in absolute justice and direct cause and effect.
- **Traditional/eclectic:** If a person's spiritual practices are conservative, it may be quite important to locate a spiritual adviser of their specific denomination/sect/etc. However, a person with a more eclectic philosophy may be able to benefit from an ecumenical spiritual adviser or an adviser from a tradition different from their own.
- **Integrated/distinct:** These are my awkward terms for assessing the degree to which a person's spiritual values affect their daily life. Some people participate in a religious community as a social activity and do not consciously include spiritual considerations in their day-to-day decision making, while others see even the most minor decisions as having spiritual implications.
- **Communal/individual:** The degree to which a person is part of a community that shares their spiritual values. The community may be formally structured (for example, if the patient is a member of the Catholic Church) or loosely structured (the spiritual practices of many Native American people are like this).

While this particular person approached the task using a very objective, almost intellectual approach, the categories chosen were revealing and provided a great deal of understanding about this person's spirituality, which was based in the Native American culture.

Another tool that is often used to elicit awareness is journaling. The assignment is to write down any thoughts and feelings that occur, especially those related to

spirituality, right at the moment of the thought. These thoughts are to be placed in context, with the surrounding circumstances also noted. The journal entries can be quickly reviewed and used as a starting point for discussion. The entries can be either positive or negative. Positive entries are important for they provide an understanding of the ways in which a person's spirituality is supporting them, and enabling them to cope with life. Negative entries are the equivalent of what might be called confession, a revealing of the dark, the failures, and the unpleasant. By acknowledging these things, gaining self-awareness, the door is opened to healing. To the extent that a failure, doubt, or negative feeling is known and examined, it may be changed or healed.

Another potential intervention would be to have patients develop a cognitive map of their spiritual journeys (this tactic can be used with both individuals and groups). This is the same exercise clinicians sometimes use to explore their own spirituality. The basic assignment is for the patient to record their spiritual journey, from their first awareness to the present moment. What were some of the key moments along the way? What impact did these key moments have? How did they affect the journey? The educational goal is to help the learners understand where they are at the current moment, as well as the process involved. What do they affirm, and why? What do they reject, find abhorrent, and why?

The goal of these interventions is to create awareness in both the clinician and the patient. What does the patient believe? What are his or her values? What are the basic underlying 'rules' that influence his life, for good or for ill? Through these interventions, the clinician begins to gain an understanding of the pivotal issues and, more importantly, the patient gains critical self-awareness. This awareness is a basic building block for transformation. As the knowledge is explored and the rules, beliefs, and values evaluated, the way is opened for change and growth.

Questions for reflection

- Have you ever had a moment when you suddenly became aware of a new truth about yourself, or aware of a feeling that had previously gone unnoticed?
- What was the catalyst that led to that new awareness?
- In what ways did that new awareness influence your current feelings, thoughts, or behaviors?

Interventions to stimulate reflection and change

The next set of interventions is designed to be evaluative in nature. These interventions involve a significant shift in characteristic as they are more proactive. The interventions related to information gathering intentionally leave the control of the encounter in the hands of the patient. These interventions, while respectful of the patient and non-coercive, are more directive. The free information offered by the patient is responded to in such a way as to amplify, challenge, and reframe.

Questioning focuses on the filtering patterns of deletion, generalization, and distortion. We have already proposed that it is important to notice when people omit information, fall into vague generalizations, or distort reality to fit their beliefs or values. Questioning not only notes the filtering pattern, but essentially challenges it.

For example, a person, when talking about God, might say, 'My relationship with God is not working.' This is a deletion because no insight is given into the nature of the relationship, or the nature of the problem. For clarification, we must know more. The appropriate intervention involves asking questions that fill in the gaps. 'In what ways is the relationship not satisfying?' 'What has happened that makes you feel your relationship with God is not healthy?'

The same basic strategy works when a patient generalizes. A patient says, 'I never do anything right?' This of course is an obvious example of a generalization. An effective intervention would clearly challenge this statement. It could be as simple as replying with 'Never?' Another patient might say, 'I just can't seem to be spiritual.' This generalization can be challenged simply by asking, 'What stops you?' The goal is both to gather more information and to break the patterns of thought that are limiting the patient from growth and healing.

Distortion, as we have noted, is when people change the meaning of an event to fit their own versions of reality. Most people don't recognize that their distortion is not, in fact, reality but merely their perception. Sometimes distortions take the form of mind reading. 'You hate me.' Or the patient may distort cause and effect, invalidly attaching either a cause to an effect or an effect to a cause by stating, 'I made God reject me.' When faced with what seems to be a distortion we can again ask clarifying questions. 'How do you know I hate you?' 'How exactly did you make God reject you?' Again the purpose of questioning the statement is to gain more information, challenge existing patterns of thought, and open up new options.

Ready and Burton, in their book on neuro-linguistic programming, offer the following suggestions to those who would deal with universal patterns, or what they call 'the Meta Model.' First, if multiple patterns are present, they suggest clinicians 'challenge distortions first, then generalizations, and then deletions.' If one starts with deletions, they caution, he or she may get more information than can be processed. The process as they define it is simple – first listen actively and spot the pattern, then intervene with the right question(s).¹⁰

A similar tactic involves directly challenging irrational ideas and moving the patient toward more rational, less self-defeating ideas. In his book *Reason and Emotion in Psychotherapy*, Albert Ellis identifies a number of what he calls irrational ideas. That list includes the following.

- 1 It is a dire necessity for me to be loved or approved of by everyone for everything I do.
- 2 It is easier to avoid than to face life difficulties and self-responsibilities.
- 3 I should be thoroughly competent, adequate, intelligent, and successful in all possible respects.
- 4 Human happiness can be achieved by inertia and inaction.
- 5 Because something once strongly affected my life, it should indefinitely affect it.

It is clear how such thoughts could well create significant problems. No person, for example, can live up to the standard of being loved or approved of by everyone for everything her or she does. Trying to live up to that 'life rule' will create frustration

and probably lead to hopelessness. Similar problematic ideas can emerge from the spiritual realm. 'God demands righteousness, any time a person is not righteous, God punishes.' We hesitate to call them irrational, since what is irrational to one faith system may seem perfectly logical to another. But we can certainly classify them as problematic if they involve standards or ideas that are inherently defeating. The key is the impact the belief or value has on the patient. If it is causing dis-ease, if it is hindering their ability to feel connected to the sacred or other, or if it causes them to be 'stuck,' unable to move forward to healing, then it is a problematic thought.

When such an idea is expressed, the clinician's goal is to help the patient rethink the rule. One effective way to intervene when faced with problematic thoughts is to use what one author calls the A-B-C-D-E system:¹¹

- A stands for activating event
- B stands for belief system
- C stands for consequences
- D stands for disputing the problematic idea
- E stands for new emotional consequence or effect.

The following dialogue illustrates how this system might be used in the clinical setting.

Patient: I should have known I would get something like cancer. I knew God would eventually punish me for failing to be righteous.

Clinician: Well, you seem to believe that your cancer is somehow connected to your behavior, and that God has caused it. Are you actually saying that this cancer is your fault?

Patient: Well, I know God is angry with me, and I've always believed that something like this would happen.

Clinician: It seems like you are struggling with the news you have received, and that you are trying to find a reason for the cancer afflicting you. It also seems that you have regrets about the way you have lived and believe God is angry at you. Let's think about these ideas for a moment. Let's start with the event (A) that started this chain of thoughts, that's your bone cancer. To that you've added the belief (B) that God wants to punish you for the way you've lived. This has resulted in you thinking (C) that the cancer is God's punishment of an unloved person. Let's think about those beliefs again. What makes you think you've deserved God's anger and that the cancer comes from God?

Patient: I'm not totally sure. But I look at the Bible and I look at other Christians and I know my life just doesn't measure up. So I just put two and two together...

Clinician: I'm sorry, but I just can't agree with you. I understand your feeling that you may not have lived an exemplary life. But I just can't make the connection between that and your cancer. Your type of cancer happens to all kinds of people. I wonder if instead of telling yourself your cancer is a sign God is angry, you can tell yourself the cancer is just a bad event, and that God, rather than being angry, is sorrowful, and wants to be with you and for you? (D) And I'm wondering in what ways

you feel your life is not good enough. Is it possible your expectations are too high?

Hopefully such a discussion, which is brief and entirely possible within a clinical session, would begin to effect (E) a new emotional state for the client, that of hope rather than despair.

Another intervention that can be used within a clinical session is that of 'reframing.' As one source defines it, "'reframing'" is a psychotherapeutic intervention which can address complex relationship dynamics, especially at times when it appears that coping and adjustment are being thwarted by reliance on unhelpful beliefs. Reframing as an intervention serves to introduce new views and possibilities.¹² The key to reframing is helping people understand they can deal with issues when they have a balanced view of that issue. It is when a person is trapped on one end of a spectrum that they lose options. As Propst notes, 'Dysfunction, distortion, and pain result when our thinking in any of these categories is at one of the polar extremes.'¹³ Death, for example, can best be explored in the context of Life. A sense of being alone or disconnected can be comprehended more fully in the context of connectedness.

When people have unhelpful beliefs about their problems, one task of the healer is to offer alternative views when suitable. This is done by addressing both sides of a particular theme. The objective is to reframe one side of the problem in the context of the other. As Bor *et al.* suggest:

Discussing the complementary aspects of an idea can help to change the patient's perceptions of a problem, leading to emotional and behavioural change. This can be achieved where the patient comes to a different understanding of his situation by making new connections and recognizing alternative but plausible perspectives to a problem. In the seemingly hopeless situation of a fatal illness, a patient may, for example, recognize the extent of caring and closeness in his family for the first time.¹⁴

With this process the clinician does not invalidate the existing perspective held by the patient, but 'balances' that perspective with the appropriate complement. This helps to move the person to what might be called 'middle ground.' The patient's view of the problem must not be invalidated. The end of the spectrum the patient has embraced should not be denied or rejected. Instead the patient's perspective is to be expanded, carefully and with great sensitivity, to include more than the original polar extreme.

This approach is extremely helpful when a person's condition is life changing (permanent), chronic, or terminal. For people whose disease has them focused on death or dying, helping to balance their views and begin to think once again about life and living can be enabling.

Patient: So, I'm going to die, there is nothing you can do?

Clinician: From all the tests, I believe that this syndrome will eventually lead to your death. But there are always things we can do to help. We might be able to slow the progress of the disease down. We can work to preserve your function and we can control many of the symptoms. I think, realistically, you have between six months and a year, based upon your current condition.

Patient: Well I guess that's it.

Clinician: How are you feeling right now?

Patient: Numb. A bit frightened

Clinician: What is it that frightens you?

Patient: Death. No, not exactly the actual fact of dying, but the process of dying. My situation is hopeless. There is nothing I can do. What will my pitiful future be like? All I can see at this point is the fact that I will, month by month, slowly become less functional. Pretty soon I'll just be a lump of flesh.

Clinician: It is frightening to think about the progression of such a disease. I can certainly understand your fear. But I am wondering – are there ways in which you can see yourself taking advantage of the time you have left? Are there things you'd like to do?

Patient: Well, it is hard to get past what I am losing. I really love walking, getting outside in nature, but I just can't do that anymore, I always fall.

Clinician: I know it is hard to walk right now. But I think we should find ways to help you keep living, and do the things that are important to you. Let's look at some options...

It would be foolish to suggest that by helping patients find balance we will magically solve their problems. This process may well be merely an initial step toward wholeness, and it may take ongoing effort and specialized help for the process to be completed. Still, the process has the potential to create a new openness and receptivity to options.

Those interventions focused on facilitating active reflection about beliefs and values are certainly not inclusive. But these strategies are brief and are not overly complex. More sophisticated tools belong to the realm of psychotherapy and are not generally appropriate for the integration of spirituality into the healthcare setting.

Questions for reflection

- Think of a person who clearly used one of the universal filters (distortion, deletion, or generalization). What would an effective challenge/question be for that statement?
- Think of an 'unhelpful' thought or life rule that you have heard a patient express. Why do you think the rule is 'unhelpful?' Use the A-B-C-D-E tool to craft a response to that statement that would help the patient to a new stance.
- Think of a key issue that you think influences your patients (or yourself). What is the complement of that issue? (For example, the complement for hopeless is hopeful.) Imagine your self being out of balance. What does it feel like to live on one end of the spectrum? What would it mean to move into a balanced position? How would that impact your potential options?

Interventions to stimulate change and growth

It usually is not the role of healthcare professionals to provide long-term therapy. They have neither the time nor the training needed for intense and complicated spiritual counseling. This does not mean, however, that they cannot be catalysts for change. Already, by helping to create awareness and by questioning and challenging the beliefs and values of their patients, they have initiated the process of healing. Awareness alone may be all that is needed. Once aware of the issues at hand, the patients can move forward to create solutions for themselves. At other times, the patient may need additional input, such as disputing and questioning, to move toward spiritual healing. And, in some cases, it may be necessary and helpful to introduce interventions that have a healing focus. Some of these interventions may be focused on the clinical session, while others may involve homework or referral. The common denominator is that these interventions tend to involve actions that are beneficial to people from a spiritual and, at times, physical perspective.

One such intervention involves what are commonly called **relaxation techniques**. Perhaps the most well-known proponent of this intervention is Herbert Benson MD, of Harvard Medical School. Benson is convinced that a person benefits greatly when they integrate spirituality into the healing process. As he reflects upon his own professional development he notes the following:

I became convinced that our bodies are wired to benefit from exercising not only our muscles but our rich inner, human core – our beliefs, values, thoughts, and feelings ... I could not shake the sense I had the human mind – and the beliefs we so often associate with the human soul – had physical manifestations.¹⁵

One of the interventions Benson believes is most effective is relaxation techniques. These techniques facilitate what he labels the 'relaxation response.' According to Benson 'the human body is geared to react by providing this calming state ... whenever the mind is focused for some time and disregards intrusive, everyday thoughts. In other words, when the mind quiets down the body follows suit.'¹⁶

There are a number of procedures for facilitating relaxation that can be used within the context of spirituality. One such procedure is very physical in nature. The patient is asked to tighten a muscle, focusing on the tension. Then the tension is slowly released and the focus of attention moves to the sensation of relaxation, with an awareness of the differences between the states of tension and relaxation. This total body exercise can be taught quickly in the clinical setting, and then used by the patient at home. Later, the patient is asked to tighten and relax muscles in sequence, starting with the hands, moving up the arms to the face, then moving down to the chest, abdomen, and finally the legs and feet.

Jim Gordon, in his Mind/Body seminars,¹⁷ teaches a technique that involves relaxation only. The patient is taught a sequence of phrases which they repeat to themselves for the purpose of relaxing the body and dilating the veins. The process follows a sequence similar to that used above and goes as follows.¹⁸

- 1 Take a few minutes to concentrate on relaxing your whole body. Shake your shoulders, inhale and exhale deeply and slowly a few times, and clear your mind of thoughts and concerns.

- 2 Next, focus your attention on your left arm and repeat to yourself over and over that it is getting heavy and it is getting warm. Continue this repetition until you actually feel that your left arm has become very heavy and very warm.
- 3 Do this for your right arm, each of your legs, your stomach, your chest, your neck, your head, and your face. Focus your attention on each body area in turn, repeating that it is getting very heavy and very warm.
- 4 Continue this relaxation until you feel the tension flow out of you. Feel the tension flow into the couch or the bed you are lying on. (You may fall asleep during all this, but it's more likely you'll feel awake, but very quiet in body and mind.) Let yourself rest there, quiet and relaxed, for 10 minutes or so. You will feel calm and refreshed when you arise. (Note: this relaxation technique gets easier and more beneficial each time you use it.)

Often this technique is used with a surface thermometer to provide the patient with tangible evidence of its impact on the body. Such techniques have many characteristics of self-hypnosis and often mirror commonly used techniques of trance induction.

Another potential intervention involves the use of **spiritual exercises**. These exercises can be 'denominational' or 'ecumenical.' Denominational exercises may involve activities or rituals related to a specific religious perspective. Ecumenical exercises will be broader and have a universal application. This is a very useful approach for people who are depressed or feeling frozen spiritually. By picking tasks that help patients gain knowledge or information and nurture the spiritual side of their beings, we can help them move forward and successfully implement a new option. The process is relatively simple. The first step is to work with the patient to define a problem that needs to be addressed, or a positive goal that the person would like to reach. The next step is to define a strategy to solve the problem or reach the goal, and divide that strategy into specific stages. The development of these stages is very important. For more complex projects, a larger number of stages should be developed. The condition of the patient will also affect the number of stages, and thus the rate of change. An individual who is very vulnerable or shy might need to take smaller steps. A small step, successfully accomplished, is better than a larger step that is unreachable.

One woman felt that she was incapable of building meaningful relationships. She felt she could not develop friendships, but extended that sense of incompetence to doubting her intimate relationships and her relationship to the sacred. As a result she felt very disconnected, and visited her family medicine clinic with vague complaints. Her family physician had become a primary connection in her life. Once her sense of isolation was understood, her family physician helped her set an initial goal of meeting more people and establishing one new friendship. The first small step was merely to gather the telephone number of some singles' groups in her community. Given her spiritual history, the step was even more defined, as only faith-based groups were to be included in the initial effort.

Once the goals and action steps have been developed, then it is helpful to identify rewards for the completion of each step. Since people struggling with dis-ease may

have difficulty giving themselves positive rewards, this can be an added therapeutic element. The rewards should be chosen by the patient. In the case above, the first award was a new dress.

The simple task of connecting to another person would be a beginning step. A next step might involve using a spiritual exercise out of that person's faith perspective as a way of building a relationship with the divine. One physician used the simple tactic of having a patient read the Old Testament psalms. One psalm was read at the beginning of each week, with the patient looking at both the nature of the psalmist (who in most cases is far from perfect) and the response of God (which is graceful and restorative). Indeed, encouraging patients to read books that address their spiritual issues is a solid way to create growth and movement, provided the books are compatible with the patient's spiritual background.

Meditation is a widely acclaimed intervention that crosses many spiritual perspectives and can have a variety of forms and purposes. It can be used for relaxation, awareness, and centering. It can be used to focus on God. In mind/body medicine it is used to facilitate healing in the body.¹⁹ Most definitions of meditation address the concept that meditation helps a person focus their attention. Some definitions include the following.

- Meditation is focusing one's attention in one direction.²⁰
- Meditation is 'consciously directing your attention to alter your state of consciousness.'²¹
- Meditation is 'Sitting still, doing nothing.'²²
- Meditation focuses on 'quieting the busy mind.'²³

Meditation can be implemented in a variety of settings. Some clinicians will lead their patients through a meditation within a clinical session. Others will provide a taped meditation experience for the patient to use, either in the clinic or at home. Others will teach patients meditative techniques and encourage them to use those techniques regularly between clinical sessions. It is also possible to use meditation in a group setting.

Many websites provide training in meditative techniques, as well as specific meditations. Training in meditative techniques specifically focused on physical and mental health clinicians is available through organizations such as Jim Gordon's Center for Mind-Body Medicine²⁴ and Herbert Benson's Mind/Body Medical Institute.²⁵ In some communities meditation groups are available through local organizations, including religious groups, non-profits, and even health systems.

It is a fallacy to believe that interventions using meditation are complex or difficult. Herbert Benson often uses a simple meditation process that takes no more than 15 to 20 minutes.²⁶ Only a quiet environment is needed: a setting where one can be quiet, undisturbed, and in a comfortable position. The process has two simple steps: the silent repetition of a word, sound, phrase, or prayer; and the passive return to the repetition whenever other thoughts intrude. The simplicity of these instructions makes this technique available to virtually anyone, regardless of spiritual or religious beliefs. This is because the person can use as their repetitive focus a prayer or any other words that reinforce their beliefs (e.g. 'God is love').

Mindfulness meditation is another popular approach to meditation that involves the ability to focus completely on only one thing at a time. In other words, the mind is full of whatever is happening right now. This can include walking, cooking, sweeping the floor, dancing, watching a bird, hearing the sound of a river, or any

other focus a person chooses. Whenever stray thoughts intrude, the person simply returns his or her focus to the current moment. This is a traditional Buddhist approach, and has been widely popularized by Jon Kabat-Zinn PhD in the Stress Reduction Clinic at the University of Massachusetts Medical Center in Worcester.²⁷

With guided meditation, a leader or tape provides the patient with a sequence of instructions that shape the content of the experience. The following meditation is one suggested by the Center for Mind-Body Medicine. It is used during their training seminars and is posted on their website.²⁸

Allow yourself to sit back and relax – Loosen any clothing that feels tight – remove your glasses if you wish – see that your arms and your legs are in a position that feels right for you. And if you are comfortable with it, slowly and gently close your eyes.

And allow your attention to move to your breathing. Let your breathing become even and comfortable. Breathing is one of the most powerful conscious influences you have on your nervous system.

So now I'd like you to see yourself in a very special place ... it could be a real place – a place you may actually have been – a beautiful spot in nature or comforting place in your own home. Your special place may be an imaginary place – a place in fairy tales – indoors or outdoors – it doesn't really matter. Should more than one place come to mind, allow yourself to stay with one of them.

The only thing that matters is that it is a place in which you are completely comfortable and safe... You feel comfortable and safe. Appreciate this scene with all of your senses. Hear the sounds – smell the aromas, feel the air as it caresses your skin – experience the ground securely under you – touch and feel the whole environment that you are in.

Notice what you are wearing.

Notice what you have on your feet.

What time of year it is, what time of day.

How old you are.

Whether you are alone or with another person or people.

Notice the colors that surround you.

What is the temperature? Is it warm? Is it cold?

Notice the qualities of the place that make it safe and comfortable.

And look around you to see if there is anything else that would make this place more safe for you... Perhaps something that you need to remove from the place or something you need to bring in... And then notice how your body feels in this place... and now take some time to enjoy this feeling of safety in your special place...

And now thank yourself for taking the time ... this time for yourself ... and perhaps promising yourself, and reassuring yourself that you will visit this place or some other place on your own, whenever you need to.

And when you're ready ... at your own pace ... let your breathing deepen... Very gradually let the awareness of your body against the chair return... Bring yourself back slowly and comfortably... And now when you are ready ... and only when you are ready ... gently open your eyes with a smile on your face.

Guided imagery can have very specific spiritual content if it is deemed appropriate. For example, one physician, when working with Christian clients, guides them down a road where they meet and talk with the resurrected Christ. Another has patients go to a 'special place' and in the unique environment meet and talk with a 'special person,' a spiritual mentor, God, Jesus, Buddha, whomever they want to place in that role.

Many of those involved in the mind-body medicine movement make wide use of mental imagery as a type of meditative technique. Mental imagery involves using mental pictures to imagine changes in the body. Sometimes the person simply does a body scan. Starting in the head, they imagine themselves being able to move down through the body, seeing the bones, muscles, and organs, imagining the entire body as healthy and whole. If there is an illness, they are asked to focus on that illness. A person, for example, with a tumor, can imagine that tumor, aided by a description provided by the physician, and then picture that tumor shrinking, disappearing. A patient with chronic pain might imagine that pain is melting away and dripping like a warm liquid out of their body. This is a highly personalized technique, and the patient would use images that are uniquely exciting and meaningful to them. Again, many of the principles of clinical hypnosis are integrated into this approach.

Studies of mental imagery have found that people can actually influence their immune functioning as well as significantly reduce pain and tension in the body with this method.²⁹ But aside from the physiological benefits, which take some practice to achieve, there is also the benefit of the person feeling empowered, having that sense that they have been able to channel their energy into a healing activity.

Certainly, when talking about spirituality and healing, we would be remiss if we did not mention **prayer**. Many faith traditions, and many people, consider prayer an important resource with respect to healing. According to Gallup, 90% of Americans pray. Of those who pray, 97% believe their prayers are heard and 95% believe they are answered.³⁰ When a group of seriously ill pulmonary patients were surveyed, 90% said they believe prayer could aid in recovery.³¹ When a group of hospitalized patients were asked about effective pain management strategies, 64% said prayer was a critical management mechanism. It was third, topped only by pain pills (82%) and IV pain mediation (66%).³²

Prayer is for many, patients and clinicians alike, an effective intervention. Some clinicians, if requested, find it meaningful to pray with their patients. This prayer can be spoken, or it can be a matter of prayerful silence. In some cases, clinicians who are not comfortable praying with a patient will offer that patient the freedom to pray, and then will sit with the patient in empathic silence. Others refer the patient to a chaplain if one is available.

We must be careful with this particular intervention. A recent article on professional boundaries notes that 'a physician who initiates prayer without first being asked presents an ethical problem because patients might easily feel coerced.'³³ The authors of this study eventually concluded that in most cases it is best for the physician not to pray with their patients.

Physician-led prayer is acceptable only when pastoral care is not readily available, when the patient is intent on prayer with the physicians, and when the physician can pray without having to feign faith and without manipulating the patient. Under these circumstances, one recommendation

that is acceptable to the secular physician is to simply listen respectfully as a patient prays.³⁴

In the hospital, it is most appropriate to refer those who desire prayer to the chaplains. The physician may choose to stay with the family and patient while the chaplain offers the prayer. In the cases where there is no other option, physician-patient prayer must be done with authenticity or not at all.

Many clinicians find the most appropriate use of this intervention is to pray *for* their patients, within the context of their own spiritual perspective, rather than to pray *with* them. The key to this intervention is to make sure it is patient-centered (and is about their faith not ours) and is respectful of each person's belief system.

Certainly the suggestions offered here regarding healing interventions are only representative of the possible options. It is our hope that these ideas provide a starting place to develop your own set of interventions. Remember that each person is different. Interventions should be chosen carefully to be respectful of the person's unique spiritual culture. Always check with the patient about their interest in such an intervention. In the context of a relationship built on trust, it is possible to have an honest discussion with patients about the degree to which they would like spirituality integrated into their care. It is noteworthy that both of the mnemonics (HOPE and FICA) provided earlier in the book end with a question about whether the patient would like to address spirituality as part of their treatment.

Collaborative interventions

As we have noted before, the degree to which clinicians can address spirituality in the healthcare setting is limited by such factors as training, time, and the acceptance of their health system. Even if they choose to address spiritual issues as part of the therapeutic process, there comes a point when the needs go beyond the capacity of the physician to meet them.

Just as there are times when a clinician must refer to a specialist because of the complexity of the physical condition, so there are times when the clinician must refer to a specialty because of the spiritual condition. When this time comes there are actually many options.

If the patient is in a hospital or nursing home, a **chaplain** may be available. Chaplains are spiritual specialists trained to address spiritual needs in the healthcare setting. They are highly trained and, as part of their code of ethics, committed to affirming 'the religious and spiritual freedom of all persons.' They also pledge that they will refrain from imposing doctrinal positions or spiritual practices on persons whom they encounter in their professional role as chaplain.³⁵ This inherent respect for the spiritual culture of the patient makes a chaplain an excellent resource. Clinicians with hospitalized patients can refer patients with spiritual issues to the chaplain program confident that the approach will be appropriate. As with any referral, it is important to get the patient's permission to make that referral. Chaplains also make the rounds of the various wards and offer patients their services in a direct manner. In some cases chaplains will discuss a critical issue with a patient and, with the patient's permission, inform the physician of that issue as it relates to recovery. We strongly suggest that clinicians become familiar with the chaplain services at the hospitals to which they admit patients. The development of

a professional relationship with the chaplains will aid in both consultation and collaboration.

Another critical resource may well be **local religious leaders**. They provide services to patients being referred from outpatient settings and to patients in smaller communities where there are no professional chaplains. It is important to refer patients only to those leaders who are appropriate for the patient's unique spiritual culture. If a person has a pastor, rabbi, or other such leader, they will probably be the best referral option. There may be instances when this is not the case. If the spiritual issue has strong moral or ethical overtones, the patient may not want to deal with that issue within their own community of faith. One patient, dealing with a great deal of guilt over an extramarital affair and subsequent sexually transmitted disease, preferred to talk about that issue with someone other than his own pastor.

Again, it is important for healthcare professionals to become familiar with the religious leaders in their community. In small communities, it may be helpful to meet with most of the leaders personally. One physician, upon moving to a new community, invited each of the religious leaders, including all of the various Christian ministers and a Buddhist monk, to join him, one by one, for a short meeting. Over coffee or lunch they had the opportunity to talk about how they envisioned working together. Although one pastor stated quite clearly that he didn't want the physician to 'mess with' his parishioners, most of the encounters were very useful. This kind of tactic may not be practical in a larger community.

In general, it is good, even in larger communities, to find clergy who are open to and appreciative of the process of counseling and nurturing of those in their care. This process of referral to local clergy is not easy. There is the issue of confidentiality. If the patient is not part of a faith community, it may be difficult to ensure that the patient follows up with the spiritual leader's care. It may be difficult or impossible to get information back from the pastor. In spite of these difficulties collaborative care with a spiritual leader can be a critical and powerful intervention.

In some communities, there is a group of persons called '**spiritual counselors**.' This term can mean many different things. Sometimes a person called a spiritual counselor is really a minister on a church staff who does 'counseling.' This person may, or may not, have formal training in counseling techniques. If they are attached to a denomination, it may be best to limit referrals to those from that denomination. In other instances, spiritual counselors are licensed therapists or counselors who intentionally integrate ideas of spirituality in counseling. In other instances, spiritual counselors are people who focus on chakras, auras, energy medicine, healing touch, and other such 'spiritual' approaches. For some people, this kind of approach may be very appropriate, while for others it would be totally inappropriate. When making a referral it is important, again, to know something about the counselor involved so that you can make the appropriate referral based upon the patient's spiritual culture. One general quality we seek in any counselor is a willingness to be patient-centered. Spirituality means different things to different people. Therefore, it is important that the counselor first assess the client's beliefs to know how to proceed with the therapy.

Mind-body medicine focuses on the interactions among the brain, mind, body, and behavior, and the powerful ways in which emotional, mental, social, spiritual, and behavioral factors can directly affect health. It regards as fundamental an

approach that respects and enhances each person's capacity for self-knowledge and self-care, and it emphasizes techniques that are grounded in this approach.

Mind-body practitioners can include physicians who add various mind-body techniques to their array of tools, social workers, psychotherapists, spiritual practitioners, and those who teach or lead practices such as yoga. There is currently no easy way to define local resources, other than taking the time to research those resources through the use of the internet and the phone book. However, finding mind-body practitioners can be exceptionally helpful for physicians who would like to provide mind-body interventions for their patients. Although many clinicians do learn to use these techniques themselves, some find it more helpful to find others who can provide this kind of care as a collaborator.

Referrals can be made to **groups** as well as to individual counselors or guides. Often there are a variety of groups available to those patients who need and want to do spiritual work. There are support groups and study groups. One church in Portland, Oregon has an ongoing group for people who have suffered a significant loss. The loss may be due to a death, but is not restricted to that scenario. People who have lost a relationship, for example, might also be involved in this group. The group is lay led and rarely has a planned agenda. It is a time for sharing and learning. People tell stories, sharing both struggles and successes. They read passages from sacred texts, or from other writings that have been helpful to them. They often engage in group meditation. Such a group might be a wonderful referral for a patient who is struggling with loss and grief. Again, the key is knowing what is available. One office in a moderate-sized community has the front office staff do research to discover all of the groups available in its community. The list is updated regularly. Each clinician is given a copy of the list, which provides the name of the group, its focus, and contact information.

When it comes to spirituality, the role of the healthcare clinician is, primarily, as a catalyst. Thus, the art of referral is one that should be nurtured. Little has been written about this important activity, and it appears that it is inconsistently carried out, especially in the outpatient setting. As we reflect upon this task, it appears a number of issues are dominant.

- First, it is important to know what resources are available in the community.
- Second, it is important to develop an appropriate method for referral. This method may need to be negotiated with the religious leaders and counselors themselves. How do they want to be contacted? What do they charge? What is the best way to ensure that the patient follows up on the referral? There are many details that need to be worked out.
- Third, it is critical to define how information will move back and forth between the healthcare professional and the spiritual specialist. What information will the healthcare provider give to the specialist? What kind of authorizations or permissions need to be in place? How will information be given back to the healthcare clinician? In other words, what kind of continuity and follow-up will be possible?

These issues must be addressed to move the integration of spirituality and medicine forward.

We recommend that any clinician who is thinking about the integration of healthcare and spirituality think in terms of a multidisciplinary care team. It is this team that provides the wide range of expertise and variety of settings that help

people identify, address, and resolve spiritual, emotional, relational, and physical distress. Although a healer may do a great deal on his or her own, it is important not to narrow one's vision of what can occur to include only that which can be done alone. In terms of the integration of spirituality and healthcare, less is not more.

Summary

This book is all about the patient. We believe that it is important, first, to understand the patient as a whole person, not just as a physical entity with a disease. Patients must be seen as complex and multifaceted beings who must be treated in a holistic manner. All aspects of the self, the physical, social, emotional, and spiritual, are intrinsically related and impact one another. Thus, in the treatment of patients all these aspects must be explored and addressed. To treat patients from only the biomedical perspective is to turn them into a cadaver.

It is also important to remember that each person is unique. Each patient who walks through the door of a clinic for treatment has a unique personal culture. We must take care to understand that culture as we work with them. A part of that personal culture is an equally unique spiritual culture. Any attempt to work with a person around spiritual issues without first examining, to at least some degree, this culture is dangerous and inappropriate. And it is from the perspective of the patient's culture that all efforts must progress.

The goal is to help the patient move toward healing. Healing, we must remember, is sometimes distinct from cure. It involves finding such things as hope, love, and empowerment in the midst of illness, which is a state created by both physical disease and internal turmoil or dis-ease.

In order to move toward this goal we must accomplish three major tasks. First, we must gather information. We must work with the patient so that we both gain an understanding of what is happening physically and spiritually. In this process both the patient and the clinician gain a new level of awareness – in most cases both about themselves and the other. Second, we must think about our new knowledge. What is going on here? What is happening spiritually that either aids or hinders the healing process? What needs to be nurtured and supported and what needs to be challenged and changed? Third, there must be action. Clinicians and patients must affirm and encourage what is working. In other instances clinicians and patients must take action to facilitate change and growth. In many cases the therapeutic relationship expands at this point to include others, such as families, chaplains, spiritual leaders, and counselors.

This is important work. We approach it for many reasons. We seek this integration of spirituality into healthcare partly because it works and partly because patients find it meaningful – but mostly we do it because it adds a new dimension, a new depth to the process of healing. In a way it is, as James Gordon insists, 'a new medicine.'

The new medicine that we are creating together appreciates the great value of surgery and drugs but sees them as last resorts, not first choices. It makes use of the most sophisticated modern diagnostic techniques and research studies, but also puts value on the learning and experience that humans in all parts of the world have accumulated over millennia.

This new medicine understands that each of us ... is unique, a whole person – biological, psychological, spiritual – in a total social and ecological environment. It acknowledges that each of these dimensions of our lives can be both a source of our distress and an arena for relieving it...³⁶

In a way, what we are talking about is also the 'old medicine.' It is a combining of the advances of modern sciences with the wisdom of the ages and the inner soul.

This is not about religious agendas. It is not about the beliefs and values of one person being imposed on another. It is about physicians and patients working together to find life and healing in the face of death and illness. It is about the 'art' of healing. William Blake in his poem 'Auguries of Innocence' writes:

He who binds to himself a joy,
Does the winged life destroy;
But he who kisses the joy as it flies,
Lives in eternity's sunrise.

It is our hope that this book will enable healers of all types to remember that newness and life, not permanence and death, are at the heart of what they do, and to find new depth and joy, and new satisfaction and effectiveness as they practice their art.

Notes

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- 16 Benson H (1997) *Timeless Healing: the power and biology of belief*. Fireside Books (Simon & Schuster), New York, NY, p.127.
- 17 For information about Gordon's workshops for professionals, visit the Center for Mind-Body Medicine website at www.cmbm.org.
- 18 <http://uasteph.tripod.com/Relaxation.htm>. This exercise is from a site called 'Beyond the Body Betrayed.' The site was developed by a 21-year-old female who has struggled with a number of spiritual, mental, and emotional issues and is in recovery.
- 19 An excellent overview of the various kinds of meditation can be found at www.meditationcenter.com.
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- 24 Information about the Center for Mind-Body Medicine can be found at www.cmbm.org. See also Gordon JS (1996) *Manifesto for a New Medicine*. Addison-Wesley Publishing Co, Reading, MA.
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