

SPIRITUALITY IS NOT A TOOL

We Are Body and Spirit. Can We Heal the Divide?

By CAROLYN J. NICKERSON, Ed.D., M.S.N., M.A., RN, C.N.E.

I don't think mortal healers should be credited with the power to make holy ... but I have no doubt that such healers are properly obliged to acknowledge and respect the holiness embodied in all creatures, or that our healing involves the preservation in us of the spirit and the breath of God. Healing is impossible in loneliness; it is the opposite of loneliness. Conviviality is healing. To be healed we must come with all the other creatures to the feast of Creation ... — Wendell Berry¹

In every clinical health care setting, pastoral and spiritual care is a standard resource. Collaboration between clinicians and spiritual care providers is more evident in some specialty settings than in acute care,² though the quality of collaboration varies widely where the prevailing culture tends to distance clinicians from spiritual care providers. As seasoned clinician, spiritual care provider, patient and family member, I have witnessed failures at collaboration between clinicians and spiritual caregivers. Differing assumptions about health, illness and healing operant in members of each provider group seem to be at the root of these failures. Where mutual respect for differing worldviews and approaches exists, collaboration is conducive to deep healing and sometimes cure. When there is tension between providers' worldviews, patients' needs are decontextualized and spiritual needs are, at best, recognized and accommodated; at worst, marginalized, derided and subject to commodification as means to the medically defined ends.

Health, illness and healing are central to the concerns of all care providers, and they shape our thinking about patients' needs. Unfortunately, our most deeply held and sometimes contradictory assumptions about these phenomena too often remain unexpressed and unavailable for cross-disciplinary examination. There is good reason for concern about this issue since "between one-third and one-half of patients report that religion is the most important strategy used to cope with the stress of medical illness and health problems."³

I urge that we make tacit assumptions about health, illness and healing more explicit and hope that this effort will lead us to a fresh place of comfort with our differences as clinicians and spiri-

tual caregivers and to a stronger commitment to mutual respect and dialogue. Here, I paint these assumptions in broad strokes as characteristic of two paradigms: the prevailing, powerful *dominant* and the less accepted *alternative* paradigms. In reality, I know these differences are more complex and nuanced than I suggest, but the contrast can create the dialectic necessary for the birth of a new perspective.

DOMINANT PARADIGM ASSUMPTIONS

Twenty years ago, Judith A. Smith⁴ reported the wide spectrum of health definitions used in the literature. Definitions varied from the most narrow, *clinical* conception of absence of disease to

the very broad *eudaimonistic* one of health as the realization of an individual's human potential. In today's dominant paradigm, health remains defined narrowly as the absence of disease and framed in terms of the individual, notwithstanding the growing prominence of the community health ideal. Most clinicians pay lip service to social and emotional dimensions of human health.

The health care industry has been organized around cure of disease and amelioration of symptoms of disease, some would say inordinately so. In the dominant paradigm, treatment goals and management strategies relate to the medical diagnosis. Clinicians' healing efforts are directed to solving problems effectively by "doing things to" recipients of care, remediating or eliminating the presenting problem and answering questions that evolve as care proceeds. Attention is directed pretty exclusively to the body; even psychiatric and behavioral health efforts are focused on affecting brain chemistry. Such interventions are rooted almost in basic empirical or medical scientific research.

Clinicians' interventions are largely unidirectional, top-down phenomena, provider to patient. There is little mutuality in the form of close, authentic provider-patient relationships. Moreover, this interaction occurs in the territory of the clinician, a setting where the health care provider is in control. In this era of fiscal constraints, emphasis on cost-effective, efficient treatment and cure make brief clinician-patient encounters the rule. These constraints distance clinicians from patients and one another, and they whittle away at the physical, narrative and moral proximity necessary for authentic healing relationships.⁵

Efforts to re-integrate spiritual care into health care have been chronicled and the research about them summarized.⁶ However, this work served to improve methods of inquiry more than practice.⁷ This shortcoming may be a function of the ascendancy of medical science in the health care arena but also of clinicians' sense of unpreparedness for spiritual care.⁸

Where efforts to integrate clinical and spiritual care have developed, criticism is leveled at the approaches being used, largely because what prevails among clinicians is an "experiential expressive" account of religion in which it is believed to be "a private matter [that] cannot and should not be judged with respect to its content."⁹ The content of patients' belief systems is not explored

because it is considered irrelevant. Here, spirituality is at risk of becoming a commodity, with instrumental value for cure and recovery from illness, rather than a powerful influence on patients' worldviews and global beliefs.

THE ALTERNATIVE PARADIGM

The Western scientific paradigm gradually achieved its ascendancy in the post-Enlightenment period when previously unified conceptions of health and holiness became divided. Health came to be defined in more particulate-deterministic ways. Some mending of this divide has begun to occur in the still marginal complementary and alternative medicine movements. In one recent survey, clinicians who espoused integrative and alternative versus traditional medical care reportedly defined health as "balance and as the free flow of elements such as motion and energy."¹⁰ Few clinicians' definitions of health contained elements of this alternative paradigm, although many included elements from the models of health heretofore described as separate in the literature.

The dominant paradigm is solidly grounded in distinctively individualistic, Western assumptions about what it means to be healthy. In the alternative view, health-related values, attitudes and beliefs are more reflective of collectivist cul-

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tures where interdependence is valued over individuality. Illnesses, distress or problematic behaviors are seen as an "imbalance in human relationships, as a disharmony between the individual and his or her group, or of being out of synchrony with internal or external forces."¹¹ This perspective implies that healing may involve far more than the application of medical therapeutics to individuals with health problems.

In the alternative paradigm, transcendent relationships are important to health. Although five types of spirituality exist in the United States,

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three “moored” types and two “unmoored,” moored spiritualities comprise 85 percent of the population. Members of these groups are the patients most often represented in research about spirituality and health.¹² The three moored types represent the monotheist faith traditions, Christian, Jewish and Muslim, whose spirituality is often oriented toward God. Their spiritual beliefs ground their perceptions of self and values and find expression in their emergent lifeways.

Spirituality has been found to have a powerful impact on people's worldviews and great significance for their perception of and response to illness, hospitalization and recovery or possible death.¹³ These findings support a cultural-linguistic perspective in which spiritual beliefs are acknowledged as “complex interpretive schemes ... [for] a religious community or culture.”¹⁴ Here the content of beliefs does matter, and the impact of those beliefs on self-perception, self-care, values and lifestyle becomes legitimate for evaluation. Here one can ask whether the impact of belief and images of God are salutary and life-giving or destructive, stultifying and deadening. This perspective represents a sharp contrast to the dominant experiential-expressive account of religion mentioned earlier.

The cultural-linguistic perspective of religion and health is reflected in a whole person model of human health as it applies to persons with physical disabilities. The model, adapted by medical humanist Lynn Underwood, proposes that, although many dimensions of a person's life may be disrupted by disease or disability,

... there is a central essence that remains intact and can provide a way to live beyond these limitations ... an integrative core that

lies deeper than the other dimensions of function. If various elements are not functioning correctly, it can cause distress and disruption, but the human being need not be destroyed ... he can define himself more fully ... the Heart provides a place where various forces can be integrated into a whole that is healthy, despite the limitations of various dimensions.¹⁵

Underwood's model reflects the wisdom of ancient Eastern and Western perspectives on health in which connotations of health and holiness overlapped. They included some seemingly incongruous, mundane and secular aspects of human experience in their respective conceptions of “holiness,” including the vitality of the body and one's functioning in life work and relationships. For many of these traditions, health still includes and may even be synonymous with holiness. Health as holiness is reflected in the old English word for both, *hael*. Presbyterian pastor George Bonnell notes,

Holiness is not some wispy sort of spirituality ... A holy person in Shakespeare's time was a healthy, mature individual — full of interest in others, teeming with physical and spiritual vitality ... in John Wycliffe's translation of the Bible, the word ‘health’ was substituted for the word ‘salvation.’¹⁶

This alternative approach is grounded in the ancient, venerable traditions of philosophy, humanities and theology. In today's language, it is attentive to a unified *bodymindspirit* not unknown to the ancients.¹⁷ In this approach, self-care rises to a level of importance equal to cure, mutuality in provider-patient relationships is valued and both provider and patient stand on common, holy and mysterious ground. Negotiation, vulnerability and reciprocity characterize their interactions. Living into healing is paramount — even when dying is imminent. Deliberate attention is paid to shape a compassionate healing context in which proximity between care providers and recipients of care is valued and cultivated.

CULTURAL HUMILITY BREEDS COMPASSION

Culture contributes to identity. In educational preparation and practice, clinicians are acculturated into ways of thinking and acting that extol only what is sensible, functional, tangible and mea-

surable. The larger culture also leaves its mark on our identity as persons and clinicians. We become “circumference people ... with little access to the center ... [living] on the boundaries of our lives ... claiming the superficial as essence.”¹⁸ It is not that this modern tendency to be occupied with surface issues’ characteristics is bad, it is just not sufficient for whole person care.¹⁹ I would argue health care clinicians cannot afford to be “circumference people” because of the sacred healing trust with which we are invested.

Clinicians and spiritual care providers come from two different cultures, where beliefs about health/illness, spirituality and healing typically stand in contrast. Yet an ethic of compassionate care invites us to stand in solidarity with one another and with those who suffer so that deep healing is fostered. It invites us to mutual respect grounded in cultural competence and humility. Such humility is a depth experience. Compassion becomes more consistently available for living and practice only to those who are alive below the surface, aware of their underlying assumptions, motivations and values.

Spiritual care providers are socialized to orient themselves to patients’ deepest desires and expectations for their own health; they are cognizant that these desires are influenced by personal history, current context and cultural worldview. They are acutely aware that “decision-makers are [still] asking questions about spiritual care ... they want a clear definition of it and evidence that this ministry is helpful.”²⁰ So the need exists for spiritual care providers to be more articulate about their assumptions, beliefs, values and methods so as to be better able to engage clinicians in dialogue.

I have some confidence that spiritual care providers generally value the medical management strategies developed in Western medicine. I am less confident about how well clinicians endeavor to understand the alternative paradigm that informs the provision of *bodymindspirit* care. How often do clinicians acknowledge the importance to our work of deep consciousness of the human condition? How sensitive are clinicians to spiritual distress and how faithful are they to providing for the human spirit? To what extent do clinicians share the conviction that ongoing examination of our own deepest desires and beliefs, our assumptions, our work-

ing anthropologies, is a necessity? How deeply do we clinicians recognize our own human spiritual dimensions and allow them to be in dialogue with our scientific perspectives on health, illness and healing? How often do we seek the spiritual care we need to live below the circumference?

HEALING, BROADLY CONCEIVED

We do well also to consider the views of farmer and philosopher Wendell Berry on health and healing. He asserts it is good to honor the materiality of the body:

We speak now of “spirituality and healing” as if the only way to render a proper religious respect to the body is somehow to treat it “spiritually ...” It could be argued just as appropriately (and perhaps less dangerously) that the way to respect the body fully is to *honor fully* its materiality ...²¹

What would it mean to honor fully the body’s materiality? Could it mean that when we think of health, illness and healing we remember that we are spiritual beings on a human journey?²² We all recognize that the experience of disease and dis-

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ability can be disorienting and disintegrating. But how comfortable are we with the reality that both well and ill persons often perceive a sense in life of being “off balance,” a sense of growing and evolving into a new pattern of life? The study of chronic illness has taught us that health and illness are not necessarily opposites. Similarly, body and spirit or spiritual consolation and distress are not necessarily opposites, but may be complementary and salutary.

Researchers in the field of positive psychology have recently uncovered evidence of the value of

spiritual struggle,²³ confirming the importance of the assimilation and integration of disorientation. Healing work honoring both the clinical and the spiritual traditions is not likely to be time-efficient or predictable, primarily because it may involve personal transformation as well as recovery of physical wholeness and function. What can we do to make time in healing for balance, growth, reorganization and reintegration of lives to occur? How can *being with* patients come to be as important as *doing to* them? How can clinicians square those values with the press for evidence-based practice and care-mapping?

Berry also asserts the essential communal and environmental nature of health:

It is wrong to think that bodily health is compatible with spiritual confusion or cultural disorder, or with polluted air and water or impoverished soil ... Intellectually, we know that these patterns of interdependence exist; we understand them better now perhaps than we ever have before; yet modern social and cultural patterns contradict them and make it difficult or impossible to honor them in practice.²⁴

Our practical logic makes us rebel against this idea even though we know the truth of it. Yet we have created our respective professional social patterns that make it impossible to honor these *bodymindspirit* context interactions in practice. What would it take for us to leave the silos in which we live to form healing communities? What would be required of each of us personally, organizationally?

As clinicians and pastoral/spiritual care providers, we are invited not to a collaboration that is sentimental (and perhaps supplemental), but to one that is substantive and gives birth to compassionate healing communities for quality care. The compassion essential to effective clinician/spiritual care provider and patient-provider relationships is recognized.²⁵ We have also come to recognize the damage wrought by distancing patients and providers of all types. We must recognize the practice of distancing that has emerged and restore the “nested” physical, narrative and moral proximity to patients; one (physical) making it possible for the others (narrative and moral) to exist. The distal practice fostered by the current

culture and organization of health care “threatens [our] traditional appreciation for the particular in clinical and moral decision-making and may create a distanced, ‘we’re just running the trains’ mentality.”²⁶

It is crucial that we acknowledge that the limitations named are not mere aberrations. They have become the norm in health care culture. As products of this culture, we have come to think of these characteristics of health care as normal, even beneficial. “It is as if each of us is a fish in a fish bowl [swimming] around inside the bowl ... surrounded by water and glass [but] unaware ...”²⁷ We fail to realize how water and glass distort the accuracy with which we perceive the other’s world and work.

The tension between the assumptions of the dominant and the alternative paradigms of care challenges us to move away from defining health narrowly, clinically and individualistically and to conceive of healing in broader and sometimes inscrutable ways.

I am not an iconoclast. I continue to value the ways of Western medicine. But I have sensed its limits and lament its neglect of enduring wisdom traditions. I decry the appropriation of spiritual-

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ity as a tool valuable only for the achievement of medically defined individual. I am also averse to the notion that spiritualizing life experiences will bring acceptance, peace or resignation. Living and dying are human experience far too complex for such simplistic claims.

Both clinical and spiritual care traditions have valid truth stratagems, claims and methods. Each has a venerable history that confers competence and confidence. Understanding our differences is the first step in achieving cross-cultural competence and, more importantly, it establishes a basis for a next step, inspired by what has been called cultural humility.

Cultural humility incorporates a lifelong commitment to self-evaluation and self-

critique, to re-addressing the power imbalances in the patient-health care professional relationship and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.²⁸

How shall we proceed? I suggest that we begin by recognizing our respective limits and assuming a posture of cultural humility. Cross-disciplinary collaborative consciousness-raising efforts will help, as will collaborative inquiry into outcomes that is open to the complementarity of science, philosophy and theology for deepening our understanding of health, illness and healing. As our health care system is reconfigured, it will also be essential to develop *bodymindspirit*-oriented care resources that are community-based and community-building. In our dialogue, we are afforded the strength as well as the support and challenge necessary to refinement that should characterize professional practice. I hope we can regain and retain the ground for cultivating compassionate healing environments.

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