# REVIEW



# 'You are here': locating 'spirituality' on the map of the current medical world

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**Purpose of review**
Clinical works at the intersection of 'spirituality, religion, theology and medicine' are studied to identify various aspects of what constitutes spirituality, what contributes to spiritual health and how to provide spiritual-healers for our current health-care system.

**Recent findings**
Spiritual care in the current medical world can be classed grossly into two departments: complementary and alternative medicine, considered as proxy variable for spirituality, and physician-initiated clinical Chaplaincy, informed by theology. The large body of research on 'self' as a therapeutic tool, though, falls into subtle categories: phenomenological studies, empathy, embodied care, and mindfulness-based therapies. Development in the field of 'spiritual medicine' has focused on spirituality-related curricula.

**Summary**
As mindfulness-based meditation programs help build deep listening skills needed to stay aware of the 'self', Clinical Pastoral Education trains the chaplain to transcend the 'self' to provide embodied care. Clinical chaplaincy is the destination for health-care professionals as well as theological/religious scholars who have patients' spiritual health as their primary focus. Medical education curricula that train students in chaplain's model of transpersonal-mindfulness/empathy founded on neuro-physiological principles would help them gain skills in embodied care. Such education would seamlessly integrate evidence-based clinical practice and spiritual-theological concepts.

**Keywords**
chaplaincy and trans-personal mindfulness, empathy and embodied care, medical-psychiatric curriculum and CPE, spirituality and religion, theology and phenomenology

## INTRODUCTION

Religious/spiritual institutions and their leaders have cared for the sick since times immemorial [1■■] and patients continue to seek their help even today [2]. With invigorated scientific inquiry into the role of spirituality in health, medicine is said to be 'returning to the fold of religion' [3■]. Traditional, complementary and alternative medical systems (TCAM), clinical chaplaincy, phenomenology, mindfulness-meditation, empathy, embodied care, religion-scriptures and theological studies are some fields of scientific inquiry into 'spiritual care'.

This paper identifies the chaplaincy process, strengthened by mindfulness-based meditation program that develops chaplains' skills in 'self'-awareness, which in turn builds their deep-listening skills for providing empathetic and embodied care to be the model that for training physicians in spiritual care. Research studies on neuro-physiological mechanisms underlying such a spiritual care process of chaplaincy [4■■] would help seamlessly integrate

spirituality and medicine. Medical education curriculum and programs that are based on these studies would actually lead to development of the field of 'spirituality and medicine'. It is crucial to understand how and/or whether the field of medicine is returning into the fold of 'religion', or whether 'religion' is moving in the direction of clinical care, or if both are simply moving where the spirit meets the physical body. This article also discusses the implications and pitfalls [3■] of such an expansion of medicine into the realm of spirituality.

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## KEY POINTS

- Chaplain's transpersonal model of mindfulness involving nonjudgmental presence and unintentionality has parallels with Freudian psychotherapeutic and Gilligan's hypnotherapeutic models as well as phenomenological principles of *epochē* that helps philosophers in their study of religion.

- Phenomenological psychiatrists study patient's symptomatology and also their anomalous 'self'-experiences and regard patients' symptoms as a paradigmatic disturbance of embodiment and intersubjective experiences.

- Chaplain's spiritual care process helps a patient not only in connecting with his/her 'self' but also helps in developing rapport with the patient and reestablishes their ability for intersubjective experience leading to symptom relief.

- Understanding chaplain's spiritual care process through neurobiological mechanisms that underlie mindfulness and interpersonal empathy would help in developing evidence-based practice of spiritual care.

- By incorporating Clinical Pastoral Education rotations into Medical education and Psychiatry residency training curricula, students and residents can be trained in various phenomenological aspects and spiritual skills needed for embodied care.

- Development of the field of 'spirituality in medicine' and growing demand for clinical chaplains in healthcare would, through a positive feedback loop, hopefully induce multifaith, religious education in seminary/divinity schools and make CPE certification a mandatory aspect of all seminary/divinity school curricula.

- In identifying empathy, along with its neurobiological underpinnings, as a tool common to scriptural exegesis and clinical care, we will be able to bridge the fields of medicine and humanities.

## IDENTIFYING SPIRITUALITY IN VARIOUS CLINICAL CONTEXTS

### Spirituality and traditional, complementary and alternative medicine

TCAM is considered a proxy variable for spiritual care [5▪] and hence appropriate for incorporation into patient-care measures [6]. Medical professionals' interest in incorporating TCAM into clinical care was triggered by consumer-driven healthcare system [7▪]. To meet growing public demand more than 130 medical schools in the United States have included TCAM-related courses into their medical curriculum [8▪]. Further, to govern and regulate education and training in TCAM methods, a National Center for Complementary and Alternative Medicine (in 1998) and the American Board of Integrative Medicine (in 2012) were created [7▪]. Evidence-based approaches are being adapted to integrate TCAM methods of practice [9,10▪] into modern medicine; however, there has been little effort to understand the essence of spirituality in TCAM methods of care. Apart from offering spiritual exercises such as yoga and prayer services, TCAM schools do not provide any training or education in spirituality or spiritual care [5▪]. In contrast to the United States, integrating TCAM into national healthcare system in developing countries is for improving healthcare delivery system and not primarily aimed for providing spiritual care [11].

### Spiritual care through clinical pastoral education and chaplaincy programs

The physician-initiated chaplaincy program was started in 1925 to provide clinical education to theological students to prepare them as spiritual care specialists in hospitals [3▪,4▪▪]; more recently, growing number of nurses and physicians are joining clinical pastoral education (CPE) to obtain spiritual care skills. At the same time, a growing number of chaplains, equipped with scientific analytical skills, are contributing to empirical research publications on spiritual-care services at hospitals [12]. Chaplaincy-related publications have focused on how addition of spiritual care services may improve patient satisfaction [13▪], positively impact patients' clinical outcome [14] and alleviate stigma toward mental health services [02]. Evidence-based studies have not only identified 'good-practices chaplaincy' [15] but also lead to neuro-physiological understanding of chaplain's spiritual care process [4▪▪].

The chaplain's spiritual care process of 'listening presence' is deep and empathetic listening to the patient's thoughts and feelings. This skill is secondary to chaplain's ability to be mindfully aware of his/her own 'self', thoughts and feelings; mindfulness of another individual's mental processes is conceptualized as 'trans-personal mindfulness' [4▪▪]. The chaplain, through his/her transpersonal-mindfulness, embodies the 'self' of the patient, if only for a moment, before returning to his/her own 'self'. Moving back and forth between one's own self and that of the patient the chaplain provides empathetic but nonsuffering companionship to the emotional pain the patient may be experiencing. The patient too, having developed a rapport, starts to reflectively become mindful of his/her own thoughts and feelings, and develops self-empathy through which he/she experiences the healing [4▪▪]. Spiritual qualities such as transcendence, boundlessness, ultimacy,

interconnectedness and empathy that are studied through phenomenological and theological inquiries can be illustrated through relational mindfulness [16] and embodied care in a chaplain-patient dyad.

### Empathy and embodied care

Empathy is a process of 'knowing' another person's thoughts and feelings but 'it is not (static) 'knowledge' you have from a handbook, it cannot be written down in teachable or learnable sentences' and hence not a cognitive, rational disembodied process [17▪]. It is through embodiment that the conversation between individuals, say chaplain and patient, influences their cognitive processes; thus, empathy is precognitive. As both participants use these categories of interaction both start to empathize and embody one another thus and empathetic relationship is a bidirectional process [4▪▪,17▪]. In that empathetic state of unified embodied psyche both the patient and his/her chaplain would thrive. The process embodying another individual's thoughts and feelings is 'transcendence' and it requires renegotiation of the 'self' through the core components of the inner world, psyche, emotions and coping [18]. The spiritual qualities of transcendence, boundlessness, etc., are not mystical or magical [17▪]. Neither it is out of the boundaries of scientific inquiry.

Transformation of one's own 'self' occurs when both chaplain and patient bring their personal experience-triggered thoughts and emotions into their conscious awareness. Awareness of 'self' and intersubjective knowledge ([4▪▪], Verbatim table) acquired by embodying the psyche of the other can provide valuable insights and a new set of data for analysis [19▪] using neurophysiological principles [4▪▪]. Gilligan's hypnotherapeutic model in which the 'psychotherapist directs attention to the patient and abandons usual analytical processes of thought and perception' [20] can be studied as a validation of chaplain's application of transpersonal mindfulness. Studies on therapeutic processes involving spiritual experiences such as 'self', 'psyche', transcendence, intersubjective data and embodiment would guide us into 'phenomenology'.

### Phenomenology, psychiatry and chaplaincy

Epochē (Greek for 'suspension of judgment'), which is decisive in avoiding emotional disquiet and reaching ataraxy or mental calmness, during the study of religion is said to be the starting point of phenomenology [21▪]. Freud's recommendation of 'ungrounded attention, unintentionality, apathy without therapeutic ambition, low activation of attention, as well as discarding one's own expectations or

tendencies' as a therapeutic process [20] resonates with nonjudgmental attitude that aids a phenomenologist in observing and analyzing his/her own 'religious', transformative experience [21▪]. Although Freudian 'unintentionality, apathy without therapeutic ambition' interferes with a therapist/psychiatrists' diagnostic formulation and/or treatment plans [4▪▪], the phenomenological processes – transcendence and embodied care – eventually lead to the desired clinical outcome of ataraxy or calmness 'untroubled by mental or emotional disquiet'.

Classical approaches to studying psychiatric symptomatology through phenomenological standards suffered an 'unintended death' [22] with the arrival of criteriological methods of diagnosis using Diagnostic and Statistical Manual. This loss is being recovered [23] with the realization that phenomenological diagnosis, in comparison to criteriological, takes into consideration not only symptomatology but also anomalous 'self'-experiences [24]. Phenomenological psychiatrists regard patients' symptoms as paradigmatic disturbance of embodiment and intersubjective experiences [25▪▪]. Clinical researchers have debated for [26▪] and against [27] phenomenological approaches in understanding the 'self'. Such debates that hinge on theological view-points drawn across religious lines may find an ataractic spot in the chaplain's evidence-based, phenomenologically sound, spiritual care process that is informed by theological reflections drawn from diverse scriptures.

### Religious-scriptural studies, theology and clinical chaplaincy

A majority of physicians claim to be very religious and spiritual in their role as clinicians [11]; consequently, they take interest in theological studies. A PubMed search (as of 19 May 2015) using keywords such as Holy Scriptures, Quran, Bible, Bhagavad Gita and Torah yielded a three-fold increase in the number (144) of publications in the past 3 years as compared with 1124 publications in the past 70 years. These works of clinical researchers focus on the therapeutic application of scriptural verses [28▪,29–31] using religious/scriptural concepts. Theological scholars, in contrast, study scriptures from literary, socio-cultural and historical contexts [32], limiting themselves to intra and intertextual studies generally within a particular religious tradition. Sadly, though expectedly, as they are not clinicians, their work does not focus on explaining any clinical application of scriptural verses.

Unknown to the medical world and even barely known among theological scholars is, however, an evolving field of 'comparative theology' [33] that

encourages scholars to empathetically move back and forth between reading their primary religious scriptures and those of an alien religious tradition. In a sense, it is similar, though not identical, to a clinical chaplain empathetically 'reading' his/her patient as a 'living-human document' [34■■] or a 'text'. A chaplain's transpersonal mindfulness makes him/her move back and forth between being mindful of one's own thoughts and feelings and alternatively becoming trans-personally and empathetically mindful of the thoughts and feelings the other, the patient, alien 'living human-scripture'. Chaplains also reflect upon their clinical experiences theologically and vice versa. Thus, chaplains' methodology of spiritual care has parallels in 'comparative theology'. In identifying of empathy as a tool common to both methods, we connect evidence-based medicine to the humanities.

### Advancing evidence-based approach to chaplaincy's model of spiritual care

To the best of my knowledge, Parameshwaran's article [4■■] on 'conceptualizing chaplain's spiritual care as a 'trans-personal model of mindfulness' is the only one that presents neurophysiological mechanisms underlying chaplaincy process. This article is the best available answer to researchers' interest in finding evidence for relational mindfulness [16,35] and/or studying biological correlates for spiritual experiences [36].

Readers may refer to the detailed clinical-verbatim, a typical pedagogical process of chaplaincy training, presented as a qualitative study elsewhere [4■■]; however, summary of that clinical verbatim (diagrammatically illustrated, a reproduction from [4■■], Table 1) would help the reader better understand the neurophysiological correlates (Fig. 1 [4■■], Table 2) underlying the trans-personal application of mindfulness in a chaplain's spiritual care [37–54,55■,56–66]. Along with the chaplain's model of care, the spiritual tools such as empathy, embodied care, transcendence and phenomenology discussed in this article may be grounded in neurobiology-supported, evidence-based paradigm; findings of Parameshwaran's [4■■] publication merits further investigation [36] (Table 2) [67].

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### DEVELOPMENT OF THE FIELD OF 'SPIRITUALITY AND MEDICINE'

Chaplain's spiritual care process could help patients transcend their emotional disturbances to connect with their 'self' and reach an *ataractic* state of peace. Our understanding and/or definition of 'spirituality' or 'spiritual care' may lie in that 'search' (for the 'self' or the 'divine' and the inner dialogue with it) which helps individuals find meaning and purpose in their struggles [1■■]. Clinical chaplaincy informed by converging spiritual standards (via philosophy, phenomenology, religion and theology), studied

**Table 1.** Themes that emerge from the qualitative study [4■■] – mindfulness and transpersonal mindfulness processes during a chaplain–patient interaction (original, unpublished)

| Clinical chaplain | Patient |
|---|---|
| Mindfulness | Facilitated mindfulness |
|     Centering the self: feeling one's own emotions, thoughts and other physical sensations before entering the patient's room. |     Shares painful stories and unconsciously comes in touch with his/her own emotions while sharing their stories. |
|     Becomes aware of how own emotions, memories and thoughts are triggered while listening deeply to emotional pain and suffering in a patient's story. |     Facilitated by chaplain, patient returns and re-returns (repeats) her painful stories and thus involuntarily remains mindfully observing painful emotions and thoughts. |
|     Stays mindfully, nonjudgmentally aware of his painful feelings, setting aside his thoughts and avoiding judgmental statements or mental treatment plans. |     Gains metacognitive ability to question her/his negative automatic and thoughts. |
| |     Stops negative automatic or judgmental thoughts and starts to feel self-empathy and healing. |
| Transpersonal mindfulness | Facilitated transpersonal mindfulness |
|     Returns and re-returns his focus from his own painful emotions to be available to patient's pain and sufferings. |     Develops an involuntary resonance with chaplain's mind and reflectively imitates/mirrors the chaplain's action to stay calm even while being aware of own emotions. |
|     Remains present to patients' dynamic, ever changing moment to moment emotions. |     Patient starts to believe in the genuine good intensions of the chaplain. |
|     Facilitates patient to become aware of his/her thoughts and feelings and helps them stay with the painful emotions related to their problems in life. |     Develops rapport. Starts to feel secure and shares her thoughts and feelings without anxiety or fear. |
|     Resists urges to rush the patient out of their painful situation by providing solutions, i.e., avoids making 'treatment plans' including instructions on mindfulness. | |
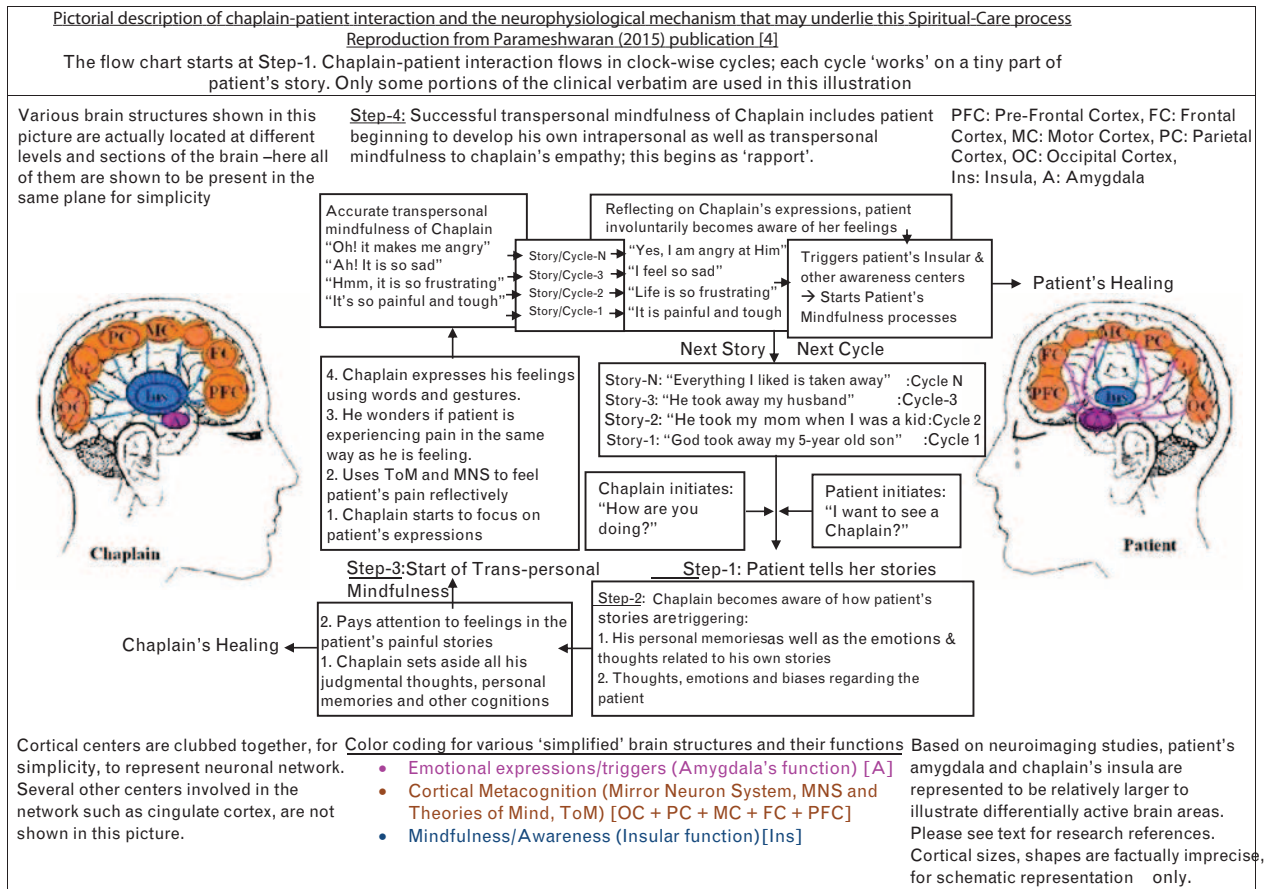
**FIGURE 1.** Pictorial description of chaplain–patient interaction and the neurophysiological mechanism that may underlie this spiritual-care process reproduction from Parameshwaran (2015) publication [4""]. The flow chart starts at Step-1. Chaplain–patient interaction flows in clock-wise cycles; each cycle 'works' on a tiny part of patient's story. Only some portions of the clinical verbatim are used in this illustration.

through empathy and transpersonal mindfulness, and which lends itself to scientific scrutiny [4""] is the spiritual care department to which 'medicine has returned'. These standards of spirituality, unwittingly tied into the clinical chaplaincy process, can be structured into medical education as well. Medical curricula that incorporate CPE rotations [67] and/or those that involve chaplains in the educational process and clinical training have been consistently recognized as exemplary pedagogic models for 'spirituality and health' programs [1""]. Though there are no available/published 'spirituality' curricula [68], the detailed information on 'national competency guidelines' for training and assessing medical students' skills in spiritual care [1""] along with the description of the chaplaincy process available at the webpages of Association of Clinical Pastoral Education (ACPE) [69] could offer some glimpse into the possible functional-structure of the evolving 'Department of Spiritual-Medicine'.

## Future directions for spirituality in medical education and psychiatric residency training programs

This article has argued for the phenomenological approach to understanding psychopathology and psychiatric diagnosis [22,23]. The disturbances of 'self', of embodiment, and intersubjective experiences [24,25""] of a psychiatric patient may be corrected through chaplain's spiritual care process, which is an exercise in establishing reciprocal empathetic and embodied relationship [4"",17"]. Psychiatric patients' lack of insight [70] that is associated with lack of 'self'-experience [70,71], and impairment of their theory of mind [72"], can arguably be improved by chaplains' model of spiritual care that imparts skills of self-experience and intersubjective empathy to their patients.

## Future directions for seminary/divinity schools

Unfortunately, CPE training is not a mandatory part of theological education in seminaries or divinity

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**Table 2.** Summary of Ramakrishnan 's arguments [4▪▪] on the neurophysiological mechanisms underlying chaplain–patient's mindfulness and transpersonal mindfulness

| Mindfulness (Can be understood as 'awareness of the 'self' and also leading to 'self-empathy') | Transpersonal mindfulness (Can be understood as 'establishment of rapport' or = phenomenological/spiritual processes such as 'transcendence', 'empathy towards others' and 'embodiment of other's 'self') |
| --- | --- |
| 1. Mindfulness exercises activate insular and cortical functions to improve the awareness of ('self') emotions and thoughts [37–44]. | 1. Chaplain's mindful empathetic presence to patient's emotional pain and suffering may be understood as trans-personal mindfulness mediated through theories of mind (ToM) [51,52]. |
| 2. They prepare an individual ('self') to be receptive to newer and ever changing emotions [45,46]. | 2. Using ToM, a mindful chaplain becomes fully attentive to patient's facial expressions, body language and emotional stories and connects those dots with his own internal emotions, thoughts and matches the patient's emotional struggles with similar ones of his own. It helps the chaplain to empathize with patient's pain/struggles [53]. |
| 3. Insula is responsible for self-awareness of internal, both nonconscious physical and emotional sensations, as well as the awareness of conscious motivations and social feelings [38–40]. | |
| 4. Improved insular and cortical activation and mindful-awareness ('self') helps in subduing amygdala leading to reduced emotional reactivity [47]. | 3. Chaplain–patient empathic loop 'lights up' interpersonal cortico–cortical connections [54] that are mediated through ToM and mirror neuron system (MNS) [55▪]. |
| 5. Mindfulness training enhances the cortical control system by integrating various parts of the frontal, parietal and even cerebellar areas of the brain responsible for meta-monitoring necessary for self-awareness and self-regulation of emotions [48]. | 4. ToM is known to help us understand the emotional intentions behind the behavior of others, MNS provides us the neural basis for that understanding [56]. |
| 6. Chaplain's ability in subduing his amygdalae is demonstrated by his ability to set aside thoughts and feelings that were triggered within him – this also helps in building his ability to suspend judgments about his patient. | 5. Empathetic behavior can be automatically grasped by the observer through MNS mechanisms [54,57–59]; chaplain's behavior becomes involuntarily and reflectively mirrored by patient's brain [60,61]. |
| 7. Effective modulation of emotional arousal by down-regulating emotional centers such as amygdala helps in cultivating compassion [37,41–44]. | 6. The clinical benefits could be because of the cortico–cortical connections [54] and the dynamic equilibrium [62] between chaplain and patient's brain. |
| 8. Mindfulness enhances 'metacognitive' awareness that negative self-depreciative, automatic, ruminative thoughts and feelings are mere 'mental events rather than aspects of or direct reflections of truth' [49]. | 7. Awareness of self and other's emotions, thoughts and intensions [63] rapport building are described to be functions of MNS [63,64]. |
| 9. Mindfulness improves individual's skills to listen deeply to understand the patient's emotions and thoughts in a better way [50]. | 8. As the patient remained aware of their emotions without feeling the need to move away, intuitively reflecting the chaplain's behavior, she understood that those thoughts and emotions are mere works of her mental activities and not actual truths [45], thus leading to self-empathy/compassion and eventual healing. [65,66]. |

schools; one could ask how seminary students are being educated and trained in the spiritual knowledge of 'self', transcendence and embodiment? Probably they are not, 24% of the clergy confess that their seminary education does not prepare them for spiritual counseling [73]. Four percentage of clergy were trained in CPE by 1962 [3▪]; currently about 2–3% of 451 685 religious professionals in the United States are hospital chaplains [73] but not all of them are necessarily CPE certified; 44% of hospitals do not require CPE certification for employing them [74]. This has to change; like clinical training that helps in the formation of a physician, only a CPE training can help a theology student experientially understand the spiritual concepts presented allegorically in scriptures. Growing demand for clinical chaplains and increased need for their collaboration with physicians [75,76] should induce policy changes

making CPE a mandatory part of theological education. Patients and families seeking spiritual counseling from clergy [77] would benefit with CPE trained congregational ministers and hospital–church liaison chaplaincy.

## Cautions

American Medical Association collaborated with religious leaders in its Committee on Medicine and Religion was terminated in 1974 because of Committee on Medicine and Religion's politics and contentious debate on abortion [3▪]. Medical researcher on ethics related to human reproduction [78,79] and withdrawing life-support of the terminally ill [75] that are based on religious–cultural directives would help a clinician develop appropriate attitudes and religious–cultural competencies to meet a patient, but such clinical education should

be secondary to CPE training in individualized, empathetic-embodied care.

American Medical Association needs to align with ACPE [68] that governs CPE training programs and with the Board for Chaplaincy Certification [80]. These organizations ensure chaplain's benign role in clinical care, rooted in spirituality that is secularized and voluntary nature of care that is dependent on patients' clinical requests, and their spiritual counseling, which does not incorporate religious content [34■■]. Because of such highly specialized training the Courts of Law have upheld the appointment of CPE-trained clinical chaplains in government establishments such as Veterans-Affair Hospital and Military despite public litigations that invoke First Amendment Act of the United States Constitution (i.e. separation of 'State and Church') [34■■].

## CONCLUSION

Chaplaincy's model of spiritual care reaches beyond the 'respect' for religion-based ethical issues; it meets the patients at their individual 'self' that may be suffering to find the meaning and purpose of their life's struggles and also matching itself with religious–cultural requirements. Far from proselytizing, and beyond known models of cognition-behavioral therapy, chaplains' spiritual care is a peculiar kind of 'psychotherapy' based on philosophical-phenomenology of using the human 'self' as a therapeutic tool. It is peculiar in the sense that it is a 'care-process' that is not provided by the chaplain but 'educates' the patient to heal him/herself using the 'self'. The teaching is 'Socratic', not 'cognitive-based'. Incorporating CPE into medical education and residency training curriculum not only helps in the formation of spiritual-scientific clinicians, but it is also a legally validated form of religious/spiritual education that can be offered in public institutions in the United States.

Chaplain's application of mindfulness in a transpersonal setting is essentially a therapeutic application of spiritual concepts such as 'self' and transcendence; from a religious perspective, with its ability to withstand scientific scrutiny, the chaplaincy process provides an opportunity to scientifically validate theological and spiritual concepts. From a clinical perspective, the chaplain's model may be the best form of spiritual care, whose methodological approach and therapeutic outcome can be measured just as we are able to measure outcomes from mindfulness-based interventions. Scientific studies on the chaplain's transpersonal application of mindfulness that brings various phenomenological and spiritual elements into play

would lead us into a new epoch of intersubjective-experiential research.

## Conflicts of interest

*There are no conflicts of interest.*

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