

Counselors' Role with Clients in Medical Crises: Human Suffering, Spirituality, and Meaning Making

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Abstract

Spirituality recognizes the search for a deep and abiding meaning to life. Mental health counselors should be able to explore with sensitivity and acceptance of a range of religious or spiritual expressions, or ways of meaning-making, with their clients. This article focuses on the subjective experience of human suffering with the potential loss of meaning versus the objective diagnosis and treatment of pathology. Counselors tasks are compared with the tasks of the medical model. An approach to psychosocial-spiritual healing within biomedicine is explored. Suggestions are made in order to reconcile historically these divergent paradigms of dealing with suffering. Cura Personalis, or the acknowledgement of the "whole person", is honored as an essential foundation for educating and preparing counselors to be of service in this suffering world.

1. The Subjective Experience of Human Suffering vs. the Objective Diagnosis and Treatment of Pathology

Cashwell (2005) noted that spirituality recognizes the search for a deep and abiding meaning to life. Mental health counselors should be able, within the context of therapeutic relationships, to explore with sensitivity and acceptance of a range of religious or spiritual expressions, or ways of meaning-making, with their clients. This article focuses on the subjective experience of human suffering with the potential loss of meaning versus the objective diagnosis and treatment of pathology. It is an elaboration of a model proposed by Cassell (1991) incorporating biopsychosocial diagnosis and treatment with holistic or spiritual elements of personal narrative and meaning-making.

There is a growing belief that sickness cannot be completely understood apart from the patient's personal lifestyle and social setting or culture. Changes in the doctor-patient relationship have shown that patients frequently perceive themselves as active partners in their care (e.g., taking part in decisions, demanding choice in therapy, etc.) and have high expectations as to outcome. Doctors who do not understand this or who are insensitive to the unhappiness, demoralization, or suffering of their patients are considered mere technicians. Suffering extends beyond the physical. It can be defined as a state of severe psychological and physical distress associated with an illness- or any event that threatens the intactness of a person. (Cassell, 1991) In this essay I will define the terms and contrast the subjective experience of the patient with the objectiveness of medical treatment.

The subjective experience of a symptom is a person's first step toward illness. Illness is defined as a person's whole condition versus disease, which is some objective abnormality in function or structure in an organism. When the symptom is taken to a doctor, it is the doctor's first contact with the illness. Although patients and doctors speak of symptoms as though they were referring to the same thing, it is not the case. Speaking diagnostically, symptoms are subjective, apparent only to the afflicted person. The subjective symptoms are differentiated from the signs that are objectively detectable to the doctor; signs that can be seen, felt, heard or deduced. The word objective has connotations of "real" in contrast to subjective which may be regarded as only "mental" and therefore unreal (or at least unimportant). (Cassell, 1991)

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The scientific view promotes acceptable knowledge: objective, predictable, reproducible versus information that is subjective, value-laden or cannot be measured-and subsequently seen as less in value, often called “soft”. Unfortunately, scientists many times disregard patient’s “soft” and immeasurable descriptions of symptoms. If examination does not confirm some pathophysiological structural anomaly to explain the pain, it may not be considered real. Yet, it is virtually impossible for a patient to report symptoms in a computer-like manner. The patient’s descriptive adjectives describe the symptom’s emotional meaning and the person’s attitude toward the symptom. (Cassell, 1991)

The contrast between the human subjective experience of human suffering and the objective diagnosis and treatment of pathology is plain to distinguish. The tasks of the mental health counselor include the facilitation and development of a counselor-client relationship with three necessary components: unconditional positive regard, empathy, and authentic encounter (Rogers, 1951). The intangibles of the counselor-client relationship illustrate subjective human experience. Jerome Frank (1961) noted the following intangibles of the counselor-client relationship: clients’ realization that they are “not alone” in their struggles, the instillation of hope, implicit client disclosure becomes increasingly explicit, insight and coping, therapeutic alliance, and the making of meaning.

In comparison, the four fundamental tasks of the physician are: to evaluate and diagnose, to determine causation and prescriptive treatment, determine the prognosis, and to affect a cure (Cassell, 1991). The tasks of modern physicians are based on the belief that persons become sick because they have a disease and that diseases are entities- structural or functional abnormalities. Thus, the task of a modern physician is to determine a disease in a sick person by locating the abnormality.

(insert figures 1 and 2 here)

II. An approach to psychosocial-spiritual healing within biomedicine

The dominance and success of science and the positivistic paradigm as manifested in medicine (and in psychology as the “received view”-Leahey, 1992) have led to the widely held prejudice that no knowledge is real unless it is scientific: that is, objective and measurable. From this perspective, the subjective experience of a sick patient is unreal or at best irrelevant. In contrast, Cassell (1991) states, “knowledge does not take care of sick persons or relieve their suffering. Rather it is clinicians in whom these kinds of knowledge are integrated who have a hand in facilitating recovery and healing.” Personal meaning of the disease arises from the subjective past as well as present conditions (e.g., cultural background, family history, spiritual or religious beliefs and values) that contribute to the effects of a disease on a person. The concerns of biomedicine and the biopsychosocial-spiritual perspectives differ in many areas. Table 1 demonstrates the contrast.

Insert table 1 about here

In each case biomedicine is focused on the biological phenomena, the disease, pain, and curing while biopsychosocial medicine attends to both the biological phenomena and the human experience of those phenomenon. Thus, illness is the human experience of the disease, healing is the human experience of the effort to recover health, and suffering is the human experience of pain. Suffering is in large part the *story* that we tell ourselves about our pain. And that story can sometimes shift the experience of that pain. An example is a wound received in warfare. The meaning of the wound (less severe) amplified the pain for those being sent back in to harm’s way and diminished the pain (more severe) for those who knew they had escaped with their lives. (Lerner, 1994)

It is possible for conventional biomedical therapies to fail in their efforts to cure, yet for profound healing to take place spiritually and psychologically nonetheless. Shamans believed that if deep psycho-spiritual healing took place, whatever energies were available for physical recovery would be released. The spiritual elements of experience help us to rise above the matters at hand such that in the face of suffering we can find purpose, meaning, and hope. The idea that pain is an aid in purification is central to the perennial philosophy of all the great spiritual traditions. For anyone facing illness and pain, it is a concept well worth contemplating.

A person in medical crisis, either the patient or loved one, may be cured of a disease yet not healed; may be neither cured nor healed; may be both cured of a disease and healed; may not be medically curable, but may be healed (a return to “wholeness of being”) nonetheless. The four objective tasks, diagnosis, seeking cause, treatment, and prognosis cannot be accomplished in absence of knowledge about both the disease and the sick person.

It is necessary for the clinician to pursue different kinds of information and integrate with general information: What threatens this person's function at this time? The clinician must discover how the patient defines the problem and what will have to be corrected before the patient will consider the problem solved. Only then can a holistic and appropriate treatment plan be generated. (Cassell, 1991)

II. Finding a reconciliation of these historically divergent paradigms

There is confusion between the experience of something and the meaning assigned to it. Meaning includes both significance and importance. In this discussion, the significance of something is what the thing implies while the importance of something is its value. People know the significance of something from past experience, the experience of others, of our bodies, and general knowledge. The aspect of meaning that is important, the value dimension, arises from all facets of a person. (Cassel, 1991) Daniel Seigel, author of the book *The Developing Mind: Toward a Neurobiology of Interpersonal Experience* (1999) and known for bridging the gap between therapy and the science of the brain, addresses the importance of meaning making and the subjective experience of the individual. He states in an interview that in the 19th-century "there was no understanding that subjective human experience – feelings – was an objective scientific reality" (Sykes, 2004, p. 33). Seigel went on to note that "stories bring together the external, observable, objective world and our internal experience of our minds" (p. 34). In addition, he affirms that "if you can make sense of your story, you can change it" (p. 34). If one can make sense of the meaning behind the story and experience he or she is in a better state to change it. Mary Mains' research on attachment indicated that it was not what happened to parents as children, but rather how they made sense of what happened to them that predicted what kind of parents they would be and how they would integrate emotions.

Personal and vicarious life experience of previous illness and experience with doctors, hospitals, medications, disabilities, pleasures or misery, successes or failures form a patient's background for illness. The personal meaning of the disease arises from the subjective past as well as present conditions. A person has a cultural background, family history, beliefs and values that contribute to the effects of a disease on a person. (Cassell, 1991). Conventional (objective positivistic) biomedical approach asks 3 questions: (1) What is wrong with this person?; (2) How did he or she get that way?; (3) What can be done about it? These questions do not mobilize the person's self-healing abilities, and therefore those abilities are not available resources that can be brought to augment medical treatment. Mental health counselors' approach that is subjective and holistic has different questions that may be answered through the discovery of the therapeutic relationship. These questions include: (1) What is right with this person?; (2) What are his or her special and unique ways of being, relating, creating, making of meaning that are his or her own natural ways of living?; (3) How can we work together to find those ways of being, relating, creating, or making of meaning?; (4) What has blocked their perception, expression or accessibility in the past? (Lerner 1994)

Suffering is both exacerbated, and alleviated, primarily by the meaning that one attaches to the experience (Lerner, 1994). Thus, as a counselor, it is important not to assume how meaning making will unfold. Many traditional healing systems of other cultures recognize the importance of sociocultural dimensions of disease and often ignore the biology of sickness (Brody & Sobel, 1980). Ken Wilber (1993), provides examples of how different worldviews might make meaning of suffering. From the Christian-fundamentalist perspective, sickness may be a punishment from God for some sort of sin. A medical model might suggest sickness is a biophysical disorder and one need not worry about psychological or spiritual treatment. Karma might view illness as a cleansing, the result of negative karma inescapable and purifying the past misdeed. An Existential perspective might be that illness itself is without meaning, but can be imbued by any meaning one makes or chooses.

A Holistic perspective might state that illness is the product of physical, emotional, mental, & spiritual factors, none of which can be isolated from the others or ignored. Treatment must involve all dimensions (often to the exclusion of traditional, effective biomedical interventions). Finally, a scientific rationalist might assert illness has specific cause or cluster of causes, some causes are determined, others are simply random or due to chance. There is no "meaning" to illness, only chance or necessity (1993). Meaning must be discovered or stated by the client and acknowledged by the professional. Paul's (1967) often cited question regarding choice of counseling model: "What treatment, by whom, is most effective for this individual with that specific problem and under which set of circumstances?" may be applied to our attempt at reconciliation of the historically divergent treatment paradigms.

The question could be restated as: What assessment, diagnosis, and treatment plan may be most beneficial for this individual? When determining what is most beneficial to a particular individual the question must be expanded to include: within his or her cultural, spiritual, religious context; with that specific set of medical signs and symptoms; in light of current stressors, developmental and historical circumstances; and the meaning thereof?

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Figure 1. The intangibles of the counselor-client relationship

- Clients’ realization that they are “not alone” in their struggle (Yalom, 2001)
 - The instillation of hope
 - Implicit client disclosure becomes increasingly explicit
 - Insight & coping
 - Therapeutic alliance: collaborative goal setting, strategies
 - Making of meaning
- (Frank, 1961, Yalom, 2001, Frankl, 2006)

Figure 2. Four Fundamental Tasks of Medicine

- observe, evaluate and diagnose
 - determine causation and prescriptive treatment
 - determine the prognosis
 - effect a cure
- (Cassell, 1991)

Table 1: The Concerns of Biomedicine and Biopsychosocial-spiritual Concerns

Biomedicine concerns	Biopsychosocial-spiritual concerns
the physical processes of <i>disease</i>	the physical processes of the disease and with the human experience of that disease which is <i>illness</i>
the relief of <i>pain</i>	concerned with relief of pain and with the human experience of the pain..., which is <i>suffering</i> .
with the physiological process of <i>curing</i>	the physiological process of curing and with the human experience of whatever is physically, mentally, emotionally and spiritually possible in the face of illness, which is <i>healing</i> .

(Cassell, 1991)