

Chapter Nine

Partner with Patients in Pursuing What They Care About

*Real change begins with the simple act
of people talking about what they care about.¹*

Margaret Wheatley

We discussed in the last chapter the idea that inquiry and intervention are joined together in a fluid process. Curiosity about another person goes along with the hope for a brighter future, and the *process of inquiry* about what has been and is important moves people in the *direction* of what is important.

An internist recounts:

I have students rotate through my office and I usually give them the first shot at working with patients, with my supervision. A student was seeing a diabetic woman with me and the conversation turned to her smoking. The student did what I presume he had been taught to do... told her about all of the health effects of smoking, black lungs, feet falling off. He asked her if she thought she should stop and she said "yes" in a somewhat hesitant, drawn-out way. He then gave her a sincere but somewhat disjointed set of instructions about keeping track of her cigarettes, how much she wanted to smoke each one, cutting out the

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easy ones first and then setting a quit date. Told her to have a supply of carrot sticks to help with the urge to hold something. "Any questions," he asked. The poor woman looked pretty bewildered but didn't have any questions. She didn't strike me as a carrot stick kind of person.

I asked her a few motivational interviewing questions... what was good about smoking (it helped her to relax) and what was not so good (she knew the health issues backwards and forwards). I asked her how much she wanted to quit and why... she said she did want to quit and the main thing for her was being able to follow her grandchildren around. Then I asked if she had ever quit before. Yes, she had, once for seven or eight years. How did she do that? She brightened as she spoke about it... she said she just "remembered her spirituality." What did this mean? She said she would just get up each morning and remember that God had a plan for her life. When she got the urge to smoke, she just "turned it over." We talked about this for a couple more minutes... she said she had been thinking that she had gotten away from her spirituality... and she left I think with some confidence that she could pull it off again. The student and I had a good conversation afterwards, essentially about the idea that the first thing you do is find out what motivates people to change and how they have managed to change before.

This is good spiritual care. The internist supports this patient in connecting to what is vital and sacred in her life. The patient is helped to reconnect to her vision of interacting meaningfully with her grandchildren, with the personal foundation of her spirituality, and with God's plans for her life.

I would not particularly call this conversation "counseling" (although we might have to use that word for billing purposes). When we think of spiritual care conversations like this as "counseling," it conjures up too much the specialty care model we discussed in Chapter 1, with the attendant feelings of weariness at the prospect of somehow needing to learn sophisticated and specialized skills.

"Counseling," after all, has its roots in the process of giving advice. You know by now that I love word origins. Our modern

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word “counsel” comes from the Latin “consilium,” meaning “plan,” or “opinion.” The medical student presented plans and opinions; the internist did not.

Rather than advice-giving, the approach of the internist was collaborative. It was exploration together with the patient of what mattered to her. The solution, in this conversation, arose primarily out of the wisdom and life experience of the patient.

There is nothing inherently wrong with advice-giving in health and wellness care. Indeed, we all have training and expertise that allows us to help patients precisely because we can give advice. I know the empirical literature on behavioral approaches to anxiety and depression. You perhaps know the empirical literature on pharmacological, or integrative medicine approaches to anxiety and depression. You may have expertise in the Western health care treatment of hypertension, osteoporosis, or irritable bowel syndrome. You may be an expert about nutritional issues. You may practice Chinese medicine and have a wealth of knowledge and experience in treating conditions that have no Western equivalents whatsoever.

This knowledge and experience that we bring to patients is often vitally important. In the realm of spiritual care, however... anchored in the journey toward what is “vital and sacred” for people and what “really matters” to them... the conversation has to welcome the values, goals, life experiences, and wisdom that patients bring.

Spiritual care conversations are a partnership. They are collaborative. You and I have wisdom and patients have wisdom. The wisdom that we all bring is directed toward patients’ goals, patients’ values, and toward what helps patients to be spiritually alive and whole.

In this chapter, I want to consider with you some practical approaches to spiritual care conversations in partnership with patients. In the next chapter, we will look at some recurring themes in these conversations, such as mindfulness, serenity, forgiveness, and valued directions.

A TEMPLATE FOR COLLABORATIVE SPIRITUAL CARE CONVERSATIONS

Having a structure or framework for organizing what we are doing guides the directions we pursue and the choices we make. As Yogi says, if you don't know where you're going, you're probably not going to get there.

In health care, we have abundant templates and algorithms to guide us in choosing particular treatments. There are good algorithms for when you get someone going on C-pap, when you prescribe hydrochlorothiazide, when you do desensitization, and when you administer moxibustion.

In the venue of integrative medicine where I have taught for a number of years, clinicians thoroughly review someone's history and presentation and then propose a multifaceted treatment plan. The elements of the treatment plans are, for the most part, specific interventions. An integrative medicine clinician might propose a nutritional program, a botanical treatment, a mind-body approach, some form of energy medicine, or Qigong.

We do *not* so much have templates in health care at the level of our *conversations* with patients. Some time ago, I recall observing a new intern... a recent medical school graduate... having a counseling session with a patient. The apparent strategy was to get the patient talking about what troubled her and to ask repeatedly, "How do you feel about that?" This seemed to be the template for the conversation... "Get them talking about troubles and get them to describe their feelings." It was not apparent that the intern had any plan for what she would do as people express their feelings. In fairness, I suspect that there was no attention at all in her medical school to working with patients at the level of conversations; she came fairly well versed in pharmacological treatments for DSM diagnoses, but not in approaches to talking with people. This young woman, by the way, turned out to be an outstanding physician.

Spiritual care, in particular, is less a matter of recommending specific interventions... although it can be that... than it is being

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intentional about how we talk with people. There are specific spiritual care interventions, as we have discussed... meditation, prayer, gratefulness approaches, chaplain consultation, and so forth... but the foundation of spiritual care is being present to people, understanding their values, and being partners on their journeys.

A template for collaborative spiritual care conversations

Three elements and some samples of conversation

Presuming a background of trust and patients feeling valued and understood...

1. Where do you want to go?

What do you care about?

What is your goal?

What do you wish to accomplish?

How would you like to be different?

How would you like to be handling this?

What kind of person do you want to be as you move through this?

2. How are you going to get there?

- a. Your (patient's) wisdom

What is your sense about what you do now?

When are the times when you feel like you're moving forward?

What have you learned in your life that applies to this?

- b. My (clinician's) wisdom

This is what the data say.

This is what my patients have said.

This is what I have learned from my experience.

3. What is the next step?

What will you do to follow up at this point?

What do you see yourself putting energy into now?

When we next meet, what would you hope to report?

The sidebar presents a template for spiritual care conversations. The template presumes that patients feel respected and understood.

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Some time ago, I spoke with a practice manager at a specialty clinic who was interested in developing a spiritual screening program. The draft proposal was that an intake worker would ask patients whether spirituality provided a source of strength and comfort to them. This particular question... whether people find strength and comfort from spirituality... is indeed prominent in the spirituality and health literature. But having an intake worker ask this question... absent of any substantial relationship with patients, alongside questions about diarrhea yes-or-no and insurance policy number... will not work. This is a question that needs to arise from a foundation of trust and healing intention.

The first element of the template is *where people want to go*. Defining how people want to be, or want to change, helps to establish a shared goal and a spirit of partnership. The second element is *how people are going to get there*. This brings together patients' wisdom from life experience and intuition, and clinicians' wisdom from empirical data, patient experiences, and personal experience as professionals and as human beings.

The final element is identifying *next steps*. I am firmly persuaded that people who leave health care visits and do something concrete to follow up have better outcomes than those who do not. It seems to me, moreover, that the specifics of what people do to follow up is less important than *that* they do something to follow up.

Let's look at these elements of the conversational template in greater detail.

GOALS: WHAT MATTERS TO YOU AND WHERE DO YOU WANT TO GO?

Collaborative spiritual care conversations are anchored in a definition of the goal. People often come to us with the mindset that they will tell us what is wrong with their lives, medically and psychosocially. It is, of course, vital to listen to and honor what patients tell us about what is wrong. It is equally important, however, to help patients move beyond the conversation about

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what is wrong and to put into words what the goal is and where they want to be going.

Future vision... patients creating a definition or image of where they want to be going... provides direction and energy, and provides a positive anchor point for our conversations with them about coping and health behavior choices.

Someone challenged by anxiety or depression: How do they want their life to be different? Someone having a hard time with diabetic control: How do they want their approach to diabetes to be different from what it is now? Someone complaining of chronic pain: What would they hope to be doing differently if they were coping with pain better?

Some examples of conversation starters that begin to explore where patients want to go:

- *What is your goal?*
- *What do you wish to accomplish?*
- *How would you like to be handling this?*
- *What do you hope for?*
- *What kind of person do you want to be as you move through this?*
- *What, in particular, really matters to you about this?*
- *How do you want your life to be different?*
- *Six months from now, what will we be seeing about how you have moved forward with this?*
- *What would I notice about you if you were a little more on top of things?*

As we think about goals and conversation starters, I particularly want to commend the quotation that begins this chapter. Margaret Wheatley is an organizational consultant who writes for an organizational development audience as well as for a broader audience of people interested in change and partnership in wider social systems. “Real change,” she says, “begins with the simple act of people talking about what they care about.”¹ Real change... not

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superficial or transient, but real change... begins with the simple act of people talking about what they care about. What matters to them. What is vitally important to them.

When you talk about what you care about, there is very different energy compared with talking about more pedestrian topics. An applicant to our residency program a couple of weeks ago was dutifully articulate in speaking with me about some of the philosophical underpinnings of family medicine. She really lit up, though, when she spoke about working in a free clinic in inner city Cleveland and about the richness in human experience and caring in which she took part there. She *agrees* with the philosophical underpinnings; she is *engaged with her heart* in having caring relationships with underserved people.

Getting people talking about what they care about... I often suggest at workshops that this is a great foundation for spiritual care.

There are a number of important principles as we consider approaches to exploring patients' goals.

Goals can be outcomes or values

You will see, from the above list, that “where you want to go” may be framed in terms of outcomes or values. **Outcomes** are typically specific, functional end points. A woman wishes to decide whether she should leave an abusive relationship. A cancer patient wants to complete a notebook for grown children. Someone who says they have been struggling for years with chronic fatigue syndrome wants to be more selective about saying “yes” or “no” to commitments. A man with chronic pain wants to get to the point of spending more time away from his home.

Values often pertain to qualities of character, as we considered in Chapter 6. The abused woman wishes to “be strong” and to “show the importance of courage and determination” to her children. The cancer patient wants to “maintain his dignity” and to “be thankful.” The person with fatigue wants to “think of myself as being as important as other people.” The man with chronic pain wants to “not give up and keep pushing.”

Goals in spiritual care conversations are rooted in the “vital and sacred”

Collaborative goals in spiritual care conversations are grounded in things that really matter to people. For both outcomes and values, goals that relate to what is “vital and sacred” in people’s lives are qualitatively different from changes people may wish to make that are more specific or prosaic. Goals relating to what is vital and sacred have very different energy from more concrete ideas or plans for change. Consider:

I think I will take up stamp collecting again.

For most of us, this is not a particularly inspiring or energizing goal. I did have a friend once whose fondest dream was finding one of those upside-down airplane stamps in an old trunk, but this would not excite most people. By itself, the prospect of re-summing stamp collecting might be a perfectly fine change someone would wish to make, but is not a particularly meaningful goal in the context of spiritual care. Consider, however:

The oncologist says that most people at Stage IV are done for in a few months. This absolutely sucks... but what am I going to do... give up and just go away? Maybe it won't be too long, but I really have to keep living my life.

“Keep living my life” in the setting of end-stage cancer is a pretty good goal. It certainly touches on qualities of determination and perseverance that probably define who this person is. If this person decided that a good way to keep living his life would be to take up stamp collecting again, the idea of stamp collecting again feels very different. It is a specific methodology in service of a personally meaningful goal, and some of the spirit of sacredness of the goal of “living my life” rubs off.

As you see in the template we are considering, I think that a definition of both spiritually-meaningful goals and of concrete steps is important. The conversation can flow in either direction.

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Patient: *I think I'll take up stamp collecting again.*

Clinician: *OK... how would you put into words why that is important for you right now?*

Patient: *I have to keep living my life.*

or

Patient: *I have to keep living my life.*

Clinician: *OK... give me an example of how you see yourself doing that right now.*

Patient: *I think I'll take up stamp collecting again.*

In inquiring about spiritually-meaningful goals, we help patients by orienting their thoughts and hearts to the core values that they cherish.

Affirming and, in a sense, expressing solidarity with people's values, moreover, are central parts of spiritual care. In the Ronald Reagan assassination attempt, the president was conscious and alert as he was removed from the scene and taken by ambulance to the hospital. Being wheeled into the surgical suite and introduced to the surgeon, Reagan flashed his noted sense of humor, telling the surgeon that he hoped he was a Republican. The surgeon replied, "Today, sir, we are all Republicans." We may or may not share the particular values that other people have, but we can honor the importance of the core values in their lives.

Clinician: *So it's looking like the tests are reassuring about the cancer... how are you doing with this... how are you doing emotionally?*

Patient: *It's good to hear, but I still get really keyed up.*

Clinician [asking how she would wish to be, "instead"]: *Keyed up... OK... how would you hope to be as you go through this instead of keyed up?*

Patient: *I just need to relax, stop thinking as much and just get a better grip or perspective on things.*

Clinician [exploring the values behind what the patient is saying]: *Could you say a little more about why in particular it would be important for you to relax and stop thinking and get a grip?*

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Patient: *Apart from the fact that I'm driving myself nuts, it really isn't fair to my husband and children to be so preoccupied... or distracted.*

Clinician: *You want to be there more for your family...*

Patient: *Yea, doing everything I can to create a good home for my family...*

Clinician [affirming the patient's values and exploring how her stated goals might be manifest]: *I can see how important that is to you. So when you say "relax, stop thinking as much and get a better perspective," say more about what that looks like...*

Goals are within patients' control

We can really only join with patients on goals that are attainable, and the circumstances that come at us are not always changeable. Many of the circumstances that I talk with people about involve the behavior of other people... partners, supervisors, children, neighbors... and it may or may not be productive to explore goals and approaches to get the other people to change their behavior. Similarly, the course of illnesses may sometimes be changeable, and sometimes are likely not to be changeable.

Patient, six months after stroke: *It's still really frustrating... I can't remember things like I used to... I can't find words like I always have been able to do... I'm really tired of people asking me how I'm doing with that sympathetic look all the time.*

Clinician [expressing empathy, sounding out likelihood that circumstances can change]: *I can imagine. What does your neurologist say about where things are likely to go from here?*

Patient: *She doesn't know... it could get better, it could stay the same forever.*

Clinician [acknowledging uncertain course of stroke effects, inviting patient to turn attention to how he wants to be living with this uncertainty]: *Actually, that's what I'd say, too. Wow... how does somebody deal with that uncertainty... so how would you hope to be handling this for however long it's hanging over your head?*

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Patient: *What can I do... just do the best I can.*

Clinician [looking for behavioral reference points that can help in defining goals and approaches]: *OK... good... and what does that consist of, for you... "doing the best you can?"*

Often, a screening question like *"To what extent do you think this is something that you can change, that you can be making different?"* gives a clear indication about whether there could be a productive conversation about changing circumstances. Sometimes, patients will answer this question... particularly when the presenting circumstances involve dissatisfaction about the behavior of somebody else... with a resounding **"NO... THEY'LL NEVER CHANGE!"** In such cases, it is good to get this reality out on the table earlier rather than later.

Sometimes there may be a difference of perspective between clinicians and patients about the possibility of changing circumstances. Perhaps your patient with metastatic pancreatic cancer retains hope for a miraculous cure. I would not want to take this hope away, and at the same time I would want to gently turn the conversation toward living with dignity for whatever time remains.

Developing collaborative goals about changing internal experiences like thoughts, feelings and somatic sensations can be particularly challenging. The pharmaceutical industry reinforces...or has perhaps created...the cultural presumption that distressing personal experiences can be summarily dispatched with pills. Sleep problems? Erectile dysfunction? Restless legs? Gas? Social anxiety disorder? Pain? Take a pill and you won't even need to call me in the morning.

With many of these internal experiences, though, the harder you try to control them, the more powerful they become. The harder you try not to be anxious, to go to sleep, or to put worrisome thoughts out of your mind, the more these experiences tend to persist and grow. In the next chapter, we will explore approaches to helping people to live with circumstances that are not controllable and changeable.

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Overall, the premise that goals in spiritual care conversations need to be within patients' control often moves the conversations toward qualities of character... as we discussed in Chapter 6. You may or may not be able to control the circumstances that come at you or the ways that the world reacts to you, but you can always choose whether or not to be kind... or grateful... or curious... or persevering.

Goals in spiritual care conversations are positively framed

People can frame goals in terms of doing less of what they don't want to do, or in terms of doing more of what matters to them. Go with the latter.

Maybe I need to be less cynical.

or

I want to be more generous.

Even though there is probably some conceptual overlap between these two statements of goals, framing the goal as becoming more generous is preferable to framing the goal as being less cynical. First, the technology or methodology of establishing behavior patterns is more substantial than the technology or methodology of diminishing behavior patterns. I'll bet you can think of twelve ways to be more generous more quickly than twelve ways to be less cynical.

Second, a conversation around positive goals has very different energy than conversations around diminishing problems. When I meet with couples in my practice, for instance, conversations around how they can understand and support each other is consistently more energizing and hopeful than conversations around how they could fight and argue less.

Strategically, the key word is "instead."

Clinician: *Hey, look at your date of birth... you're going to be 50 next Tuesday... congratulations.*

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Patient: *I'm not sure what 50 is supposed to feel like, but I don't think I feel 50.*

Clinician: *Good for you. When you look back on the last 50 years and look forward to the next 50... what do you see yourself focusing on in the years to come?*

Patient: *I think I've got to stop taking life so seriously.*

Clinician: *How do you mean?*

Patient: *I don't know... I think I always make a big deal out of things... I worry too much.*

Clinician: *OK... how would you wish to be instead of taking life too seriously?*

Patient: *Just take it as it comes.*

Clinician: *Sounds good... tell me more about that...*

The “instead” moves the conversation in the opposite direction. The clinician can explore what “take it as it comes” means to this person, and what this person can do to move more in that direction.

So it can be with any negatively-framed experience:

less depressed	>	more active
less anxious	>	more confident
less angry	>	more patient or understanding
less limited by pain	>	more functional in spite of pain
less preoccupation with illness	>	more engagement with things that matter

Goals in spiritual care conversations use patients' language

I often find it very helpful to look for or elicit patients' language for where they want to be going. I ask “How would you “put into words...”

- *What you would like to accomplish?”*
- *How you would like to change?”*

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- *How you would like to be different?”*
- *What would tell us that you are moving forward?”*

...and I pay close attention to the language they use in what they say.

In the last week, people have answered these questions...

- *I want to figure out “who Donna really is.”*
- *I want to separate myself from my children’s problems.*
- *I need to stay in the present time.*
- *I think I can handle all of this as long as I concentrate on doing the right thing.*
- *I need to work on bettering myself.*

Let me point out, by the way, that these are not cream-off-the-top, articulate, college-educated, existentially-oriented intellectuals; they are regular folk who are putting into words what they want for their lives.

When people say things like this, I pay attention and I frequently anchor conversations in their language. I do this for two reasons. First, patients’ language has richness of meaning and information. I don’t have any idea what “who Donna is” means or what “doing the right thing” means, but patients do, and they are saying this because it matters to them. Second, there is a very different energy in orienting conversations to what is meaningful for patients rather than what is meaningful to me. “How are you doing with your effort to better yourself?” has very different energy than “How are you doing with your bipolar disorder NOS?”

The principle of using patients’ language in spiritual care conversations is particularly important for language that is expressly spiritual. References to the experience of spirituality (“my spirituality,” “my faith,” “my practices”) and to a superordinate presence or deity (“God,” “Buddha,” “Spirit,” “the Universe,” “the Man Upstairs”) needs to be in language that comes from patients.

Goals may be directed toward three choices

People come to us in distress about challenging life circumstances. These may be external (such as financial hardships or other people's behavior) or internal (such as physical symptoms or medical illnesses, troublesome emotions, and troublesome thoughts). People have three choices in dealing with distressing life circumstances.

1. Changing the circumstances.
2. Coping with the circumstances.
3. Being healthy and whole in spite of whatever is going on with distressing circumstances.

Changing the circumstances. Sometimes people can be invited to define goals and encouraged to do problem-solving that could potentially change the circumstances that they face. In a sense, this is the main work of what we do in the day to day business of health care. People look to us to remove cancerous lesions, to repair torn ACLs, to collaborate with them in lowering cholesterol, or reducing the frequency of headaches. We can certainly also join with patients on meaningful goals for changing health-related circumstances that are not specifically medical, such as getting organized financially, repairing an alienated relationship with a parent, or deciding whether or not to move to that retirement community in Bullhead City.

As we considered above, the key question for goals about changing circumstances is whether this is plausible. Healing a fractured wrist with a program of splinting is possible; healing the pain of abuse by getting the perpetrator to beg for forgiveness may not be plausible.

Coping with the circumstances. The second choice in dealing with distressing life circumstances... around which we may collaborate with patients on goals... has to do with coping.

People may not have choices about the circumstances of their lives, but they do have choices about their reactions to those circumstances. When people present with painful or ambiguous situations

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Three choices in relating to life circumstances

1. Change the circumstances
 - Change the reality
 - i. out there (e.g., finances, housing, behavior of other people)
 - ii. in there (e.g., medical, surgical, self-care treatment of illness)
 - Leave
2. Cope with the circumstances
 - Change attitudes (e.g., mindfulness instead of victimization)
 - Change behaviors (e.g., kindness instead of belligerence)
3. Be healthy and whole in spite of circumstances
 - Nutrition
 - Exercise
 - Passions, fun
 - Learning and growing
 - Social connections
 - Expression of personal values
 - Connections with Spirit

that are not clearly within their control, I often ask, “*How are you coping with this?*” or “*How are you handling this?*”

For me, this comes up in two settings.

- Expressing compassion and turning the conversation to how people are handling medical problems, while they are pursuing appropriate care

So you're working with your oncologist on the cancer... how are you doing with all of this... how are you coping with all of this?

- Reinforcing people's abilities to make choices and exploring how people *wish to be* coping with circumstances

Patient: *I wasn't surprised that I'd have a flare-up of my Crohn's disease... it's been incredibly stressful at work.*

Clinician: *We've talked about the flare-up... how do you see yourself coping with the stress at work?*

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Patient: *There's not much I can do... much too much work, people out on medical leave which just makes more work for the rest of us... a supervisor who is on everybody's case and just makes it worse...*

Clinician: *Wow... is it your sense that there are things you can do to change this environment?*

Patient: *Fire the supervisor and hire twelve new people.*

Clinician: *I'll take that as a "no."*

Patient: *For sure.*

Clinician: *So if things aren't destined to change soon in your workplace, what is your sense about what you can do to make the best of it... to cope with it?*

Patient: *I don't know... I have been trying to take my breaks recently and making a point not to work through lunch... I think that helps some...*

Clinician: *Good. What else?*

Patient: *Um...*

Clinician: *Let me ask you what will feel like a silly question... if you set out to conduct yourself at work in order to make the stress get to you as much as you can, what would you do?*

Patient: *Sit at my desk and read Soap Opera Digest all day.*

Clinician: *I like your sense of humor... humor is healing.*

Patient: *I would join in the "this sucks" conversation with my co-workers at every opportunity.*

Clinician: *Good. And do you do this?*

Patient: *No, I've also been thinking recently that this really drags me down and this isn't really the kind of person I want to be... so I have been laying off.*

Clinician: *What difference does that make for you?*

Patient: *I think I'm a little more balanced... I usually try to be someone who brings calm into the world and it feels good to be that way a little more.*

Clinician: *Cool. You're describing a couple of good examples of ways that you try to cope with a pretty tough situation... giving yourself a break and being the person that you want to be. How would you put*

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into words how you would want to be coping in your workplace in the next few months?

Patient: *Balanced, I guess... more balance.*

You will notice, by the way, that neither of the last two interview transcript examples contains the word “spirituality.” They do, however, touch on personal values and qualities that are meaningful for these people. The stroke victim speaks of “doing the best he can.” The woman with Crohn’s disease speaks about “balance” and being someone who “brings calm into the world.” Spiritual care is not an enterprise that necessarily involves spiritual or specialty language... it does involve the common-sense process of meeting people where they are and helping them to connect to things that matter to them.

Being healthy and whole in spite of whatever is going on with distressing circumstances. The third choice in dealing with distressing life circumstances... around which we may collaborate with patients on goals... has to do with the choices people make about healthy and meaningful living apart from whatever ways they may seek to deal with the challenges that come their way. We can support and encourage people to live in health-enhancing and meaningful ways as they go along... like eating right, exercising, finding some pleasure and joy, learning something new, caring about the people that they love, and making choices about how they spend their time and energy consistent with their values.

In my practice, I suspect that I recommend exercise and fun as much as anything else. Exercise... such as walking, swimming, gym equipment, biking, and my own favorite of 25 years, basketball... unclog your arteries, tone your muscles, connect you with other people, and give you a sense of accomplishment. Fun, similarly, has a way of restoring the soul. I think that we culturally value fun... with its attendant joy and laughter... too little. For a number of years, I have made a point of asking patients (as well as colleagues and friends) what they do for fun. To my dismay, the most frequent

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answers I get are “Nothing,” “Are you kidding” and “I don’t have much time for fun.”

The Resilience table from Chapter 7 touches on a number of areas about healthy and meaningful living. We can also encourage people in goals around spiritual life and growth, along the lines of the dimensions of spirituality reflected in the CAMPS questions.

Goals in spiritual care conversations move patients beyond complaints

Finally, let me suggest a couple of specific phrases that I find useful in making the transition in these conversations between complaints and goals.

- *What are you trying to figure out?*
- or
- *What questions are you trying to answer with this that we can work on together?*

People bring to us all sorts of troubles. The patient says “I’m really depressed.” Now the ball is in your court to say or propose something wise that will fix them. Asking *what they are trying to figure out* puts the ball back in *their* court; it moves patients into a position where they take some responsibility for organizing the conversation around where they want to go with the symptoms they are giving you.

What I am looking for is a question from patients along the lines of “How do I...” Examples:

“Well, what can I do to get less depressed?”

“How do I deal with this?”

It is not hard to have patients state questions like these, and as they do, it moves them into the first step in taking ownership of the search for solutions.

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An additional phrase that I find useful in making the transition in these conversations between complaints and goals:

“Hm... interesting question... how do you...”

With this question, I am in effect proposing a possible answer to “where do you want to go?” I am trying to bring together a variety of concerns the patient is expressing into a clearly-framed question that I believe could be fruitful for the patient to explore.

A 56 year old woman has presented with complaints of fatigue, which have been evaluated medically with no clear etiology. The conversation has turned to her history of emotional abandonment as a child, abuse from a former partner, and alienation from a woman who until recently was her best friend. The clinician (in a spirit of wondering out loud) asks,

“Wow, interesting question... so how does someone deal with this kind of pain in so many important relationships?”

As with the question of what someone is trying to figure out, this approach can focus people’s concerns or complaints in the direction of the question, “How do I...?” When people are at the point of asking this question (such as “Yea, how do I get over this kind of pain?”), they have formed a good goal and it also moves them a step toward taking ownership of the search for solutions.

STRATEGY 13: Get patients talking about what they care about

Particularly with patients who are challenging for you, spend a little time getting to know what matters to them and what they want. Experiment with the conversation-starter questions and find a way that fits for you of understanding where people want to be going.

APPROACHES: HOW ARE YOU GOING TO GET THERE?

The first element in spiritual care conversations has to do with defining with patients where they wish to be going. The second element has to do with defining how they are going to get there.

This is, as I have said, a collaborative process. The conversation about solutions brings together *patients'* wisdom from life experience and intuition, and *clinicians'* wisdom from empirical data, patient experiences, and personal experience as professionals and as human beings.

Between the two...patients' wisdom and our wisdom... I believe that patients' wisdom holds particular value. As clinicians, we may have expertise in how people in general make changes and pursue health, but patients are experts on themselves. Their wisdom... how they have coped, how they have made changes, how they have pursued values that are meaningful for them... is important because it is specific to their lives and because they own it.

Wisdom from patients

Consider first some ways that we may solicit ideas about “how are you going to get there” that arise from patients' wisdom and experience.

Catch patients in the act of being competent. Whenever patients report some accomplishment... stopping drinking, logging blood pressures, making dietary changes, handling a motor vehicle accident with some degree of grace... I like to acknowledge that and, if possible, talk about how and why they did it. All of us instinctively try to be enthusiastic about patients' efforts. In addition to this, I think that the “how” and “why” questions can often reinforce people's competence.

“No alcohol for 5 years... wow. How did you do that?”

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“It’s striking to me that you have had this profound accident and here you are in a wheelchair, but you’re still pretty cheerful... what is this like for you and how do you do it?”

“You say you have been working on your diet... what changes have you been making, in particular?”

“You’re telling me you’re pretty burned out, but you’re still going to work and taking care of your kids... what keeps you holding it together as much as you are?”

There are three reasons for having these conversations with people, even briefly.

1. It is affirming for patients to have their clinicians recognize their efforts.
2. It gives us a window on how people individually cope with life.
3. It is more fun than talking about people’s failures.

I find that many opportunities to catch people being competent come up in passing, in comments that people make that could easily pass by unless we are attuned to hearing them. The cues that I try to be attentive to are a) when people report having started some meaningful behavior pattern, and b) when people report or imply having stopped some behavior pattern that was good to have changed. Example:

Scenario #1:

Clinician, taking history: *So how did you do in school?*

Patient: *Not so great... I was pretty messed up as a kid.*

Clinician: *“Messed up?”*

Patient: *Yea, drugs, missed a lot of school...*

Clinician: *Did you graduate?*

Patient: *Well, I got a GED.*

Clinician: *And what do you do for work now?*

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Scenario #2

Clinician, taking history: *So how did you do in school?*

Patient: *Not so great... I was pretty messed up as a kid.*

Clinician: *"Messed up?"*

Patient: *Yea, drugs, missed a lot of school...*

Clinician: *OK... you say "messed up as a kid..." so you stopped messing up at some point?*

Patient: *Yea, it took a few years but I think I pulled it together pretty well.*

Clinician: *So when did you pull it together and how did you do that?*

Patient: *I think it started when my dad died... he was killed in a forklift accident at work when I was 20... 21.*

Clinician: *Oh... sorry to hear... how did that affect you?*

Patient: *It really shook me up. I was... like I said, messed up... but I was close to my dad and I think it made me come to my senses and realize that you never know when your time's up and you've got to do something with your life.*

Clinician: *When you say "Do something with your life," say more about what that means to you...*

The first example is acceptable routine care. The second example catches the patient being competent. The clinician picks up on the presumption of past tense in the phrase, "when I was a kid" and inquires about how the patient stopped "messaging up." The patient's answer... as is typically the case with explanations of significant life changes... points to a meaningful personal value, "doing something with your life."

Catching this patient being competent and eliciting this life value is good spiritual care and is important for several reasons. First, it is affirming for the patient. Second, it gives the clinician significant information that relates to the patient's health. By the patient's own account, "doing something with your life" had the significant health benefit of helping him to turn his life around.

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Given the spirituality and health literature that we have reviewed, it is not much of a stretch to presume that the extent to which the patient “does something with his life” will play a significant role in his health and well-being going forward.

Third, it points to a direction of conversation that can address the question of “how are you going to get there?” The next exchange in the second scenario will do just that... exploring with the patient the specific methodology for doing something with life. Caring about other people, setting a good example for a child, making a difference in one’s community... whatever the patient says in providing examples of “doing something with life,” the clinician can encourage the patient in these particular approaches going forward.

Finally, hearing the story of how this person changed his life has an impact on the clinician. I have used the word, “fun,” above. Sometimes it is that, but more often for me these conversations just give me a sense of awe, honor, and energy about the ways that people live their lives. As we have discussed, I believe that this effect is good for my own well-being and makes me a better clinician.

In being alert to people’s competencies, we can give people credit for trying even if their efforts and accomplishments are off-base.

Clinician: *Made some dietary changes... cool...what have you done, in particular?*

Patient: *Well, the big thing in the last month is I switched from margarine to butter. I read that when the ingredients say “hydrolyzed” or “hydrolated” or whatever that is... it’s not good. So I switched over to butter... organic butter, mind you... for all my cooking and rolls and muffins and toast and cookies...*

Clinician: *Wow, you read labels pretty carefully. Good for you for being so thoughtful about your nutrition. Can we talk a little about butter and maybe some other alternatives?*

Look for exceptions to problem states. A second approach to eliciting patients’ wisdom about “how are you going to get there”

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is to explore exceptions to problem states... times when symptoms or problem patterns are *less* than other times.

A few words of background. The idea of the scientific and clinical value of exploring exceptions has its origins in the solution-focused therapy movement. Solution-focused therapy is an approach that grew out of the brief family therapy and problem-solving therapy movements of the 1970s. What began as a technique of “focused solution development” within the brief therapy context² evolved into an approach unto itself³ and has prompted a lively literature in recent years.⁴⁻⁸

The fundamental scientific underpinning of solution-focused therapy, as I describe it to patients, students, and colleagues, is that no human experience remains constant in level or intensity over time. If you were to create a graph of the level or intensity of any experience on the Y axis, with “time” on the X axis, the graph would *never* be a flat line.

Your moods change over time... the graph is not a flat line. How many days per month (or week or year) you have a headache changes over time. Your ratings of satisfaction with your job changes over time. The number of minutes you spend flossing or brushing your teeth changes over time. No human experience is constant.

Changes in human experiences over time are not random; they happen for reasons. Perhaps you are late going to work, so you get in and out with the toothbrush. Perhaps your dentist has gently suggested that oral hygiene is not your strong suit, so you attend to dental care more thoroughly for a while. Perhaps you feel like you are really making a contribution in your workplace and your job satisfaction is high. Perhaps you have received no expressions of appreciation since your employer gave you the gift certificate for a free turkey last Thanksgiving and your job satisfaction is low.

If changes happen for reasons, then the conditions that prompt or promote meaningful changes are potentially reproducible.

The conversation in solution-focused approaches centers on reproducible changes. For a trivial human experience, such as cutting

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the grass, there will be times when you do the job more or less efficiently and when you are more or less satisfied with the result. You can think about what made the difference... height of cut, how much you overlapped rows, whether the mower was sharp, whether you just went back-and-forth or tried to make the pattern look like Fenway Park, and so forth... and reproduce approaches associated with greater efficiency or satisfaction.

For meaningful human experience, the conversation is the same.

- What makes the difference between times when your patient is hopeful about coping with cancer or not?
- When are the times when another patient has been more successful in managing his diabetes?
- If yet another patient with fibromyalgia could “fast forward” to a time when she was doing well with this, what would that look like?

Answers to such questions point to “solutions.” What helps you sometimes to be more hopeful is a solution, as is what helps you to manage diabetes sometimes, as is what helps you to cope with fibromyalgia sometimes.

The emphasis in solution-focused conversations is on *exceptions* to problems. I am not particularly interested in when people are more depressed; I am interested in when they are less depressed. I am not as interested in when people have more headaches as I am in when they have fewer headaches, or perhaps handle them better. I am not interested in couples writing down details of their arguments with each other; I am interested in the times when they are a little more respectful, caring, and collaborative. I would focus less on why someone comes to the emergency room more frequently and more on what is going on over periods when they come to the emergency room less frequently.

By looking collaboratively at exceptions with patients, we honor and draw upon the wisdom from their life experiences.

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My experience is that solution-focused conversations are clinically useful, affirming to patients, and certainly have a different energy compared with problem-focused conversations.

As a practical matter, exceptions can be pursued in the context of past experience or in the context of an envisioned future. The particular phrasing that I frequently use to explore past exceptions is “*when are the times when...?*”

- When have been the times when you have had fewer headaches?
- When were the times when your IBS was less troublesome?
- When have there been times when you have been less depressed and more confident?
- Tell me about some times when you have been... as you say, “more at one with the Universe.”

There are two possible types of answers to such questions. Either patients will be able to describe the times when exceptions occurred and will be able to extract some meaningful ideas about why exceptions occurred, or they will be able to recall times when exceptions occurred but not be able to extract some meaningful ideas about why exceptions occurred.

If patients can identify times of exceptions and can extract ideas about how they brought these exceptions about, the conversation proceeds in the direction of “*go forth and do it again.*”

Clinician: *So when has there been a time when you stopped smoking... do I recall that you stopped for two or three years at one point?*

Patient: *Good memory... actually it was about four years.*

Clinician: *How did you do it... how did you manage to be successful with that?*

Patient: *I was living in Pittsburgh, going to nursing school.*

Clinician: *Nursing school... usually that's a hard time for people.*

Patient: *Yea, it was hard, but it was really exciting to be learning all the things you learn in nursing school... that, and I had some really good friends in school with me.*

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Clinician: *OK...*

Patient: *I think we were all pretty psyched up about being healthy, too... the instructors really emphasized that and we worked on it.*

Clinician: *Exciting to be learning things, good friends, support with other people for being healthy... are any of those things that you could be developing or re-connecting with at this point?*

If patients can identify times of exceptions and *can't* extract ideas about how they brought these exceptions about, the conversation proceeds in the direction of “*keep track and see what we can learn.*”

Clinician: *Your idea of “feeling like my normal self...” when have been some times you can recall when you have felt a little more like your normal self?*

Patient: *Gee whiz, I don't know... it comes and goes.*

Clinician: *When was the last time you remember that you felt a little more like your normal self?*

Patient: *Um... probably some time last week.*

Clinician: *Do you recall any particular day or circumstance?*

Patient: *Nothing stands out.*

Clinician: *OK, fair enough. I understand that how much you feel like yourself varies a lot day to day, right?*

Patient: *Right.*

Clinician: *Let me suggest that you keep track for a couple of weeks and see what we can learn from that. Would you be up for that?*

Patient: *OK.*

Clinician: *All right... let me suggest that you write down every night how much you felt like yourself each day... you can make up your own scale or words. The write down any thoughts you have about why you may have felt like that on each day and maybe a couple of things that you did that you wonder whether they may have been important...*

Exceptions can also be pursued in the context of an envisioned future:

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Clinician: *OK, let's think about this goal of "accepting your health." You can't do as much as you used to but you want to figure out how to accept your health and your health limitations as they are, right?*

Patient: *Yea... I used to be into judo, running... I can't do that stuff any more.*

Clinician: *OK. Let me ask you this... picture yourself in the future... maybe a few months from now... still not able to do judo or running or things like that, but accepting your health 50% more than you do now. What does that look like?*

Patient: *I'm more peaceful... a lot more peaceful... not as angry...*

Clinician: *And what are you doing, now that you are more peaceful?*

Patient: *I'd be reading to my kids more... I'd probably have chilled enough that I could really spend some time with them.*

Clinician: *Good, really connecting with your kids...*

The envisioned future points to some possible exceptions to the anger and non-acceptance that this patient has been feeling. The clinician's premise... which is probably accurate... is that this patient's meaningfully connecting with her kids will probably help her acceptance of her health and health limitations.

This underscores, by the way, the relationship of mutual influence between feelings and behavior. Most of us naturally relate to the idea that feelings influence behavior, and also to the reciprocal idea that behavior influences feelings. Being depressed or being energetic might influence whether we would visit with friends, and whether we visit with friends might influence whether we feel depressed or energetic. For purposes of identifying exceptions to problem states and potential directions for "how do you get there," the sequence is:

1. If you felt better, what would you do?
2. Do what you would do if you felt better.
3. Increase the likelihood of feeling better.

Use scaling. A third approach to eliciting patients' wisdom about "how are you going to get there" is making use of self-ap-

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praisal scales as reference points to explore lessons learned from variations in patients' experiences over time.

The core question, as I typically phrase it, is:

Think of a scale of zero to ten, with zero standing for “the pits” and ten not standing for “perfect and wonderful,” but “I feel pretty good about how I’m doing... life has its ups and downs, but I’m generally going in a good direction.” With respect to the goals we have talked about, where would you put yourself on that scale today?

I use the awkward language for “ten,” by the way, because I prefer to have the top of the scale not stand for “perfection,” and therefore to be attainable. This is a completely subjective scale, but it is fascinating to me that the number that crosses my mind as I ask patients this question is almost never more than one unit away from what they say, and more often than not hits it on the nose.

Having this numerical self-appraisal, clinicians can explore behavioral and attitudinal correlates of patients' ratings and variations over time.

Clinician: Think of a scale of zero to ten, with zero standing for “the pits” and ten not standing for “perfect and wonderful,” but “I feel pretty good about how I’m doing... life has its ups and downs, but I’m generally going in a good direction.” With respect to how you see yourself coping with your grandmother’s death, where would you put yourself on that scale today?

Patient: Six.

Clinician: OK... and when you called to set up this appointment at the end of last week, where would you have put yourself on the scale?

Patient: Oh, man... three... two.

Clinician: So... you gained three to four points between the time you called to set up this visit and today?

Patient: Yea, I guess...

Clinician: Cool. So what did you do in the last six or seven days to get yourself another three or four points on the scale?

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Patient: *I was really freaked out last week... with my parents both in the bag most of the time... my grandmother was really the one that raised me... the one I turned to...*

Clinician: *Yea, I know how much she meant to you. But let's look at how you've moved up on the scale since then... what was it that you did that helped you to move forward like that?*

Patient: *Well, I have some good friends who keep telling me it's going to be OK. But to be honest, I think the turning point was going to the cemetery this weekend and just talking to her. I know it sounds stupid, but I really had the sense that she was there telling me that I'm ready to live my life.*

Clinician: *Wow... doesn't sound stupid at all. And when you think about being "ready to live your life," what does that mean to you?*

Here, the clinician elicits the patient's self-appraisal that he has moved forward with the goal of coping with his grandmother's death and invites the patient to say more about what "ready to live my life" means. The clinician's intent is to turn the conversation... and the patient's attention... to attitudes, behaviors and values that would comprise living life meaningfully. More good spiritual care... helping patients to connect to things that matter to them.

The additional way that I find scaling particularly useful with the "how are you going to get there" question is in the exploration of gradual or sequential future changes. A minute later into the conversation with the patient whose grandmother died:

Clinician: *So you're at a "six" today. Good. I respect what you're saying about how you have been courageous in facing this in the last few days. Let me ask you... if you were at a "seven" instead of a "six," what would that look like? How would that be different from a "six?"*

Patient: *Oh, I can tell you that... the next thing I need to do is to start to go through her stuff. My folks won't do it and I really don't want them to. Pictures, books... all those things... going through her clothes and giving them away. It's not going to be easy, but I have to do it and maybe I'm getting to the point where I can.*

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The behavioral correlate of “seven,” processing the grandmother’s effects, will be both a measure of continued progress and a specific task or methodology to cultivate that progress.

Scaling questions about past and future variations can be used in countless ways:

- *Where were you on the scale at your complete low point? What did that look like?*
- *What is the highest you have been on the scale in the last year? What were you like at that point?*
- *When you are at an “eight” instead of a “three” or “four,” what in particular is different about your attitude... how do you tend to see things differently at those times?*
- *Where would you hope to be in six months with your goal of “figuring out who Michelle is?” What would you be seeing in yourself... your attitudes and what you are doing... that would tell you that you’re there?*

Just ask... theory and sense. The fourth approach to eliciting patients’ wisdom about “how are you going to get there” is just to ask directly for this wisdom.

- *What is your theory about what is going on with these emotional times and what you’ll need to be doing to move through them?*
- *What is your sense about how you’re going to keep going being an encourager and supporter in your crazy workplace?*

A physician assistant recounts:

I saw a woman, late twenties, three months postpartum, who came in having had a serious panic attack. She was going to work... she did telephone sales for our local internet service provider... when she developed sweats, dizziness, difficulty breathing. She called a friend who brought her to the ER, where they did some cardiac screening and concluded that she had had a panic attack. They gave her some benzos and told her to follow up here. I just asked her what she thought was

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going on and if she had any ideas about what could help her get a little more settled. She said that she had thought about that and wondered if this episode was telling her that she should be staying home with her child. As we talked about it, it sounded pretty clear-cut apart from the income issue. First child... she had always wanted to be a mom and it was devastating to leave her daughter every morning. There was no love lost for her work, either... she felt like she was always under the gun to make sales and always had somebody looking over her shoulder. I thought that made a lot of sense. She and her husband talked it over and decided they could make a go of it on his income, so she quit her job and did really well.

Questions about patients' "theories" or "sense" of what is going on and how they can be approaching the circumstances they face are generally low-cost and high-gain. If patients *don't* have particular theories about what's going on and how they are going to move in directions that are important to them, you're not far behind for having asked. If patients *do* have some theories or sense about how they can be getting where they want to go, however, it can help clinicians to get to the heart of the matter in an efficient way.

STRATEGY 14

Elicit patients' wisdom and competence

Invite patients to talk about what they have learned from their own life experience, particularly the more successful times... and their ideas about how they can best be proceeding with the things that matter to them.

Wisdom from clinicians

Recall again the template for spiritual care conversations:

1. Where do you want to go?
2. How are you going to get there?
 - a. wisdom from patients
 - b. wisdom from clinicians

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3. What are the next steps?

We look, now, at “2b.”

Patients, appropriately, look to clinicians for wisdom and expertise. When I fell down our icy steps last winter and injured my shoulder... I wish it had been a more glorious athletically-related injury, but that’s the way it goes in Maine in January... I consulted my colleague and friend down the hall who is boarded in Sports Medicine. I was not looking for him to elicit my wisdom about the diagnosis and healing; I was looking to him to tell me what was wrong and prescribe a plan for treatment and rehabilitation.

In the health care world, we often use the rubric of “patient education” to describe the communication of our own expertise and wisdom to patients. We “educate” patients about self-care, management of acute and chronic illnesses, expectations about surgery and rehabilitation, and so forth.

It always seems to me that the phrase “patient education” needs a context. What clinicians do in communicating their own wisdom to patients is more than just providing information; it is searching for or developing *ways* of communicating our wisdom that people can hear.

There are three ways of expressing this wisdom that I find useful.

This is what the data say. The approach that is probably deeply ingrained for most of us as clinicians is to express our wisdom to patients in the form of data. There are data about nutritional recommendations for cardiac disease. There are data about behavioral, pharmacological, and integrative treatments for depression. There are data about osteopathic manipulation for various types of somatic dysfunction.

When patients come to us with meaningful life and health goals, part of our response to the question of “how are you going to get there” is to report results or summaries of research. We can report data in dispassionate, objective terms or with more pizzazz.

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The dispassionate approach:

As I review the research about people coping with chronic pain, the three recurrent themes I see are relaxation, activity scheduling and problem-solving. Let me say a few words about each of these and we can talk about where you think you might wish to go from here...

The more-pizzazz approach:

We're talking about the idea that pain is not "in your head," but that things in your life do affect your experience of pain. There's a cool example of this in research from World War II that I like to describe to patients. Researchers identified a large group of soldiers who had had battlefield injuries that were serious but not fatal... people who had lost arms or legs, who had serious head wounds, and so forth. For this group of people, they searched out a comparable number of stateside civilians who had comparable injuries... people who had lost arms or legs or sustained serious head wounds in motor vehicle accidents, for instance. Then they asked these groups of people for their self-ratings of pain. For the same injuries... battlefield versus stateside... what they found is that the soldiers reported significantly less pain than the civilians. There was no physiological reason for them to experience less pain, since the injuries were the same. The researchers' conclusion was that the difference was what the injuries meant to these two groups of people. If you are a comfortable civilian and you lose an arm in a motor vehicle accident, your world is turned upside down and what you see is disability stretching out in front of you. If you are a soldier and lose an arm in combat, this means that you are going to get a medical discharge, survive the war, and get a ticket home to people you love... probably a pretty good tradeoff for most people in Sicily or Normandy or Guadalcanal.

I say "pizzazz;" this type of approach to reporting data emphasizes the human context and significance and, as in the example of the matched control pain research, engages the listener with a narrative.

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This is what my patients have said. Patients are often captivated and moved by the experience of other patients. As with the reporting of data, clinicians can communicate the experience of other patients in more global and summary form, or in more personal, narrative form.

The global/summary approach:

As I talk with couples about the kinds of restoration of their relationships that the two of you are considering, I look for what makes the difference between couples that make it and couples that don't. One of the consistent things I notice over the years is that the couples that don't make it put a lot of effort into trying to change the other person. The couples that make it put their effort into exploring how they can change to become better partners.

The more personal, narrative form:

I had a patient a while ago who had been raped. She thought she knew the person well enough to be safe with him, but she was wrong. It was one of those cases where she didn't report the rape soon enough to gather the appropriate evidence to make a viable legal case, so the man was never prosecuted. He immediately dropped out of her life and she didn't have any contact with him or feel in any danger, but she struggled with being furious with him. She felt rage for weeks and weeks after the event and found herself ruminating about all sorts of ways she could extract revenge. Being a peaceful sort, she knew she wouldn't act on these thoughts of revenge, but they haunted her... kept her up at night. She saw her friends less and less and started missing work. This went on for several months. Then she said that one night she heard a voice saying to her, "The best revenge is living a good life." She didn't know quite what to make of this, but she thought about it for a couple of days and says that it dawned on her that the more she pulled back in living her life and allowed herself to be preoccupied with the rape, the more she kept the rapist in the position of violating her. By "living a good life," she took away his power over her.

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Like the narrative description of the matched control pain study, stories about patients can captivate the attention of listeners. For most listeners, there would be a qualitative difference between a clinician expressing the concept “*It’s important to go on living your life and not give him power over you*” and the clinician expressing the same wisdom in the form of the narrative.

Narratives, of course, have to safeguard patients’ confidentiality. There are a few patients over the years who have specifically invited me to tell their stories, even with personal identification, but I routinely disguise the particulars of stories in such a way that real people are not recognizable.

This is what I have learned from my experience. We are clinicians, and we are also human beings. The fact that you are reading this sentence, having picked up this book, suggests to me that self-reflection and self-awareness are values that are important to you. If this is the case, then the observations and insights from your own life may comprise part of the bank of wisdom from which you share ideas with patients.

Much of what I suggest to people about mindfulness, for instance, arises as much out of my personal life experience as it does out of reading or clinical experience. The idea of focusing mindful attention, without judgment, on this present moment has served me well with all of the concerns, questions, and doubts that all of us a human beings face.

Similarly, I have found that for myself, strategies of distraction from distress work less well than strategies of mindful engagement with something that matters to me. If I am personally preoccupied with something, I can distract myself by listening to a couple of innings of the Red Sox on the radio, but the preoccupation is still there when I turn the radio off. (And, of course, if it turns out that the Sox are getting blown out, listening to the game introduces another layer of problems that severely tax my ability to be mindful.)

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Instead of temporary distraction, however, I find that mindful engagement with something that matters to me... caring about my wife, calling my children, being a good neighbor, writing some paragraphs of a book... has a much more profound impact on my preoccupations.

It is fair game and it is meaningful to express this kind of wisdom from our own experience in spiritual care conversations as long as doing so serves the health and well-being of the patient. In a context where the conversation continues to be *about the patient*, our disclosure of our own experiences and wisdom can be compelling for patients and can help us as clinicians to come across in a more genuine way. If the context switches and the conversation becomes *about us*, it ceases to be therapeutic for the patient and it is important to return the focus to the patient's hopes and goals.

STRATEGY 15

Express your own wisdom in some new ways

In addition to customary approaches to “patient education,” experiment with expressing your wisdom in narrative forms and in sharing some lessons from your own life experience.

NEXT STEPS

The first element in spiritual care conversations has to do with defining with patients where they wish to be going. The second element has to do with defining how they are going to get there. The final element has to do with inviting patients to make commitments about next steps.

Conversation about next steps in spiritual care is important for two reasons. First, *this is how change happens*. Change... or, more broadly, people making choices that arise out of values, goals and approaches that are important to them... happens away from health care encounters. Any of us can have compassionate and brilliant spiritual care conversations with patients, but unless patients somehow follow up on these conversations in their lives away from us, not much will happen.

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The second reason is that *change is generative*. Change begets further change. Small changes create energy, optimism and momentum, which often translate into more substantial changes. A retired man, for instance, had experienced a painful divorce after many years of being together with his wife. He believed that he needed to “make a new life” for himself as a single person, but found that it was very hard to get going on some of the ideas he had about how he could be approaching this. He did not much go out, although he believed this would be beneficial. He did not cultivate some of the friendships that had survived the divorce, although he believed this would be beneficial as well. He did not put much effort into keeping up his house, as he and his wife had always done. The turning point for this man came when he decided to do his dishes. All of the two or three sets of dinnerware and utensils that he owned had been stacked up, unattended, beside the sink. One morning, he said, he decided that he had had enough and that it was time to go to work. He spent the morning cleaning it all up and commented, “It sounds silly to talk about dishes, but doing that convinced me that maybe I really could get on with making a different life.” Which he subsequently did.

Approaches to next steps. Let me suggest three approaches to the process of pursuing next steps that I have found useful in spiritual care conversations.

Jot down reactions. The least demanding option in terms of defining next steps is to invite people to think about the conversations that they have had. My experience is that the additional step of asking patients to “jot down” reactions adds an element of accountability and usually results in some more substantive reflection on conversations than there is with the simpler invitation to “think about it.”

You’ve both said that you’re a little concerned about what kinds of parent you will be after your child arrives. The fact that you’re asking

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this question... and what I know from seeing you together... make me think that you'll do fine. But let's look at this just a little more. Between now and your next OB visit, let me invite you to think about how you'd put into words what you would like to be like as parents... and jot down some ideas and bring them along.

Keep track. Particularly when clinicians and patients wish to understand something better, or when there is no readily apparent strategy to pursue for patients to move forward with goals that are meaningful for them, we can ask patients to keep track of the way things happen.

I appreciate what you're saying about finding more "dignity" in how you deal with your pain. We're kicking around some ideas about what that might look like, but at this point, it would be helpful for me to see how this plays out in the next couple of weeks to understand it better. Before your next clinic visit on the 26th, I'd like you to spend a couple of minutes every night, looking back on the day and writing a few notes about anything you did that represents some degree of dignity for you. Let's see what you notice and see what we can learn together.

Asking patients to keep track often results in clinically useful information. Beyond that, this assignment will sometimes become a useful intervention, because keeping track of some valued events tends to result in increases in those events. Asking a patient to keep track of his spending quality time with his child, for instance, will typically result in more quality time... because this is important enough to the patient to be talking about it and because he is specifically paying attention to this.

Do something different. The core feature of approaches to next steps is, simply, to do something different. I'm not sure it even always matters *what* people do differently, so much as *that* they change something about the patterns in their lives, building on what matters to them. Changing something specific about how one relates to a partner or child. Changing something specific

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about how one spends time. Making a concrete change in what one eats.

As I have suggested, doing something different generates energy and optimism; when you see something change as a result of your discretionary action, it feels hopeful. Doing something different also adds a feedback loop to the whole process of spiritual care conversations that we have been considering because it gathers wisdom and direction. When you start moving, you often get a clearer picture of where you are, where you want to go, and how you're going to get there.

We've talked about a number of issues in your life that your illness has prompted you to pursue at this point... your relationship with your mom, backing off at work, getting back into some of the creative pursuits that have been important for you before... among these things, what would you see yourself particularly putting some energy into in the next three or four weeks?

There may be an answer to this question in the conversation; there may not. If the patient has some sense of what he or she could be doing to follow up on the conversation, then this becomes the next step.

I think that the idea of your doing [whatever it is] is great and I want to support you experimenting with this between now and when we next get together.

If the patient does not have a clear sense of this, the next step can be to decide on a specific item of follow up.

In the next day or so, I'd like you to decide for yourself about one or two specific things you want to do to follow up on this conversation. I'll look forward to hearing.

My practice is that I fairly consistently write down for patients our collaborative agreement about next steps. I use a quarter sheet of letter-sized paper and write a few words about wisdom (from

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the patient and from me, as we have discussed) and next steps.
Example:

- *Talking it out, rather than shutting down*
- *Facing things, rather than pushing them away*
- *Choose some follow-up about*
 - *exercise*
 - *calming practices*

The first two items reflect the patient's language for principles that she wishes to be cultivating in her life. The third item reflects our collaborative agreement that she will choose and pursue some specific follow-up of our conversation about exercise and various calming practices.

Back in the days when we had paper records, I had quarter-sheet paper made up in NCR (no carbon required) format; I would give the patient the original copy of the summary notes and tape the yellow NCR copy in the record. Now that we are in the electronic medical record era, I give the copy of the summary note to the patient and type (or dictate) the summary from the yellow copy into the electronic record.

STRATEGY 16

Collaborate with patients in defining next steps

Invite patients' wisdom and decisions about how they could best put energy into following up with the goals and approaches from their conversations with you.

SUMMARY

A template for spiritual care conversations;

- Goals: What matters to you and where do you want to go?
 - Outcomes or values
 - Rooted in the "vital and sacred"
 - Within patients' control

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- Positively framed
- Using patients' language
- Directed toward three choices
 - Change the circumstances
 - Cope with the circumstances
 - Be healthy and whole in spite of whatever is going on with distressing circumstances
- Moving patients beyond complaints
- Approaches: How are you going to get there?
 - Wisdom from patients
 - Catch patients in the act of being competent
 - Look for exceptions to problem states
 - Use scaling
 - Just ask; theory and sense
 - Wisdom from clinicians
 - This is what the data say
 - This is what my patients have said
 - This is what I have learned from my experience
- Next steps
 - Jot down reactions
 - Keep track
 - Do something different

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