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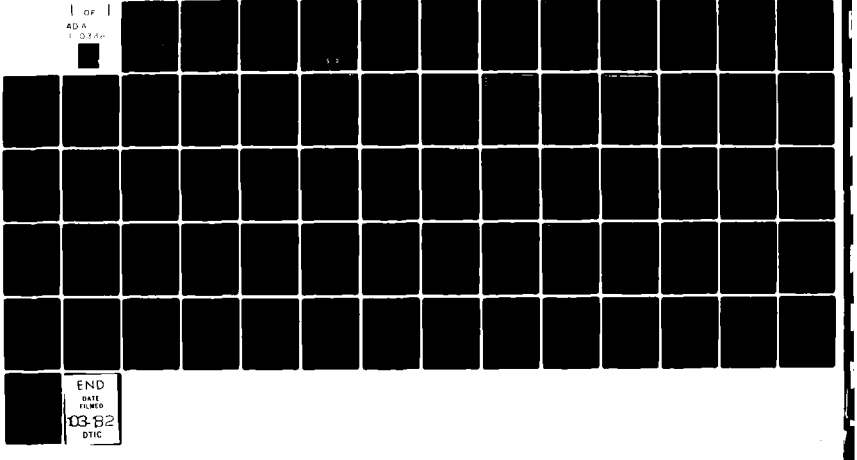

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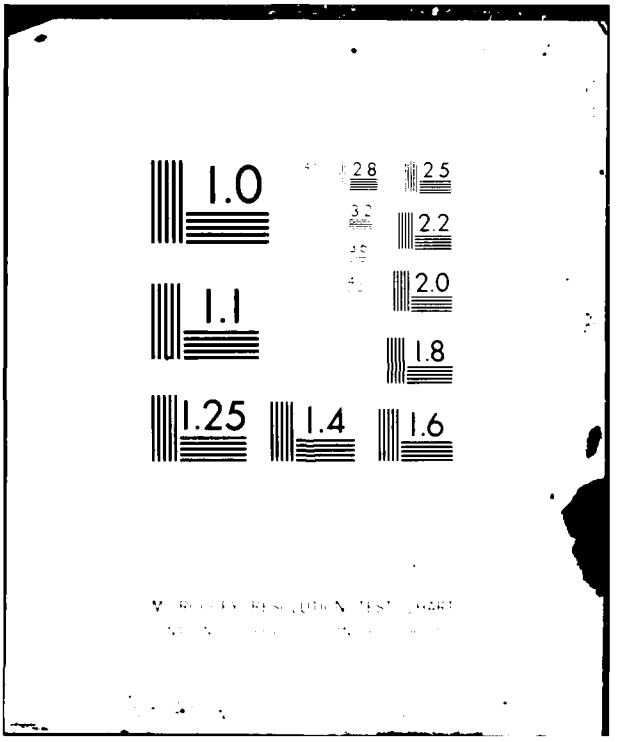
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Lawrence Johnson & Associates, Inc.

Role of the Chaplain in Ministry Related to Psychogenic Diseases

Final Report
Contract DAAG 39-78-R-9019

Lawrence Johnson & Associates, Inc.
4545 42nd Street, N.W.
Washington, D.C. 20016

October 1980

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0. ABSTRACT (Continue on reverse side if necessary and identify by block number)

The objective of the study was to identify data and recommend strategies to enable chaplains to minister more effectively as members of healing teams to persons with psychogenic diseases. Report presented suggestions for the structure of a year long training program. However, the firm did not sufficiently outline a program which could be readily implemented. The report did not provide adequate information on how ministry should be provided to patients suffering from psychogenic diseases. This report relied heavily on data which included facts already available to this office.

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20. Abstract (continue)
Consequently, no implementation is anticipated. DACH decided to accept the draft final report and require no further work of the contractor.

Role of the Chaplain in Ministry Related to Psychogenic Diseases

Final Report
Contract DAAG 39-78-R-9019

Charles N. Jamison, Jr., Ph.D
Project Director

Lawrence Jonnson & Associates, Inc.
4545 42nd Street, N.W.
Suite 103
Washington, D.C. 20016

October 1980

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CHAPTER I. INTRODUCTION

The Office of the Chief of Chaplains (OCCH) determined that there was "a need to effect a training program to enable chaplains to minister to persons with psychogenic diseases." To this end, Lawrence Johnson & Associates, Inc. (LJA) was contracted to 1) "recommend strategies for a residency program related to the medical and spiritual aspects of healings," and 2) "recommend strategies which will assist the chaplain to minister to persons with problems associated with psychogenic disease." Pursuant to accomplishing these tasks, LJA conducted an extensive literature review; conducted interviews with a variety of sources, including chaplains, clergy, physicians, psychologists, and others; attended conferences, seminars, and meetings relevant to the topic areas; and reviewed exemplary Clinical and Pastoral Education (CPE) programs. The result of these efforts is evidenced in this report outlining suggestions for the criteria and structure for a year-long training program entitled "Psychogenic Diseases: Their Etiology and Psycho-Spiritual Management." This training program is designed to prepare chaplains for a ministry to people with psychogenic diseases. On the following pages, LJA will present the rationale for the content and structure of the training course. A brief delineation of LJA's recommendations appears below:

1) LJA recommends a year-long training program entitled "Psychogenic Diseases: Their Etiology and Psycho-Spiritual Management." The proposed training program would comprise two phases.
2) Phase I would last for four months and would provide the theoretical foundation of the training program. Through didactics, training, and discussion group sessions, the etiology and management of psychogenic diseases, stress, preventative medicine, and relevant theological

issues would be explored. This phase would be coordinated by a multidisciplined team with the assistance of a programmed learning text on the psychology and physiology of stress.

3) Phase II would last for eight months and include: clinical work in a medical center with psychogenically diseased patients, discussion group sessions, and additional training where warranted.

4) Any chaplains engaged in the training program would generally be expected to have completed one year of Clinical and Pastoral Education (CPE) as a prerequisite.

Before discussing the training program and related topics, some explication of LJA's orientation regarding precursor issues to the development of the criteria and structure of the course is appropriate. This explication considers briefly the definition of psychogenic diseases and its meaning within the context of the Army and, in greater depth, the exemplary CPE programs that guided the development of this training program and the chaplain's role on Army Medical Center healing teams. For maximal utility and success any training program for chaplains related to psychogenic diseases must consider the Army context and build on the already successful Army CPE program.

Psychogenic Disease: Its Definition and Role within the Army

Simmons (1966), says that "psychogenic" can be differentiated from "psychosomatic" as the latter implies that emotional stress exacerbates an existing ailment while the former suggests that emotional stress is the etiology of the disease. LJA considers this differentiation as not functionally useful; as others in the field do, LJA considers these terms to be synonomous. However, this report primarily uses the term "psychogenic" because of laymen misunderstandings accompanying the use of "psychosomatic." It appears that many laymen erroneously confuse psychosomatic illnesses with

conversion hysteric reactions (manifestation of physical disease symptoms without any organic basis). "Psychogenic" has fewer inappropriate connotations associated with it and, as such, will generally be used in this report. Occasionally some of the researchers discussed within this report may use the term "psychosomatic," the reader needs to be aware that the two terms are interchangeable.

LOA has obtained a 1973 tabular enumeration of the dispositions by diagnosis of Army patients admitted to the health care organizations that represent the Walter Reed Army Medical Region. Table 1 presents a select listing of the 1973 tables of in-patient cases of certain psychogenic diseases at Walter Reed Medical Center. These totals represent conservative figures for the Medical Center because they do not represent non-Army personnel. Even this partial listing makes clear the chaplain's need to be aware of the role of the Army system as a contributor to the cause of psychogenic diseases.

Psychogenic considerations in disease etiology broaden considerably the factors to be considered in diagnosis. One preeminant factor is reactions to the social environment. The ensuing discussions will note some of the stressors the environment creates, individuals' reactions to these stressors, and the occurences of diseases. The Army is unique a environment with pervasive impact on all its members and their dependents. As such, the effects of the Army as a system always must be considered in any diagnosis of its members' health. During the course discussions and lectures, paramount attention must be paid to this so that the chaplain-trainees place it as a conscious focus in their ministry. With this conscious focus, the chaplain-trainees will understand that the Army system can be used to promote wellbeing, minimizing deleterious system effects.

Table 1

The number of in-patient cases of certain psychogenic diseases of Army personnel at Walter Reed Medical Center for 1978.

Psychogenic Disease	Number of Cases
Diabetes	26
Epilepsy	13
Thyrotoxicosis	10
Arthritis	43
Hypertension	70
Colitis	2
Ulcers	10
Asthma	13
Cancer	173
Hemorrhoids	14

Exemplary Clinical and Pastoral Education Programs

The chaplain involved in ministering to hospital patients must be competent not only in the theological services that his denomination offers, but also in a variety of mental health services, such as: crisis intervention, family counseling, and group dynamics. To function effectively in this capacity, many Army chaplains have their training augmented by participating in the Clinical Pastoral Education (CPE) program. CPE is a program authorized by the Association of Clinical Pastoral Education, Inc., and its purpose is to offer pastoral education and clinical experience to clergy, theological students, and lay persons. The Army not only endorses this training for its chaplains, but it offers CPE on some of its own facilities.

Pursuant to the goals of this project, LJA scheduled visits to two exemplary hospital-based CPE training sites for Army chaplains, Walter Reed Army Medical Center and Yale-New Haven Hospital. These CPE centers were identified as sites of innovative and diverse activity. At Walter Reed, LJA staff spoke with Chaplains Jesse Moore, T. Richard Denson, and Raymond Stephens; and at Yale, LJA staff spoke with Chaplains Edward Doolnle and Robert Morgan.

Discussions with the chaplains led to an explication of their CPE programs. Each Army CPE center is accredited by the Association of Clinical Pastoral Education, Inc. (ACPE), and these centers are run by supervisors who have been certified by the ACPE. It was clear that while the outline of the program at each site was similar, there was a difference in the orientation. In part, this can be attributed to the differences in the administration of the two hospitals. Walter Reed Army Medical Center is a military installation and it is oriented towards the health care team concept, while Yale-New Haven

Hospital is the only civilian CPE site with Army chaplains and it is composed of the traditionally autonomous health divisions. The differences and similarities and their effects on the CPE programs were explored in the interviews LJA conducted at the sites and are explicated below.

The Yale-New Haven and the Walter Reed CPE supervisors, in conjunction with supervisors from other Army CPE centers, annually select participants from a body of applicants for the year-long CPE program. This selection process is quite stringent and is oriented towards eliminating unsuitable applicants. Once the body has been narrowed appropriately, the applicants are divided equally among the centers, with an effort made to create a balance regarding age-cohorts, denominations, personality attributes, and applicants' location preferences. Each center typically has four CPE participants per year.

The CPE program resembles a psychiatric residency. The chaplain is exposed to a combination of supervised clinical work and didactics. The program is a year long and is divided into four units, two basic and two advanced, each lasting between ten to fourteen weeks on the average. The two basic units orient chaplains to several areas: gaining awareness of their personal and professional selves, developing an understanding of clinical issues, nurturing the ability to use their peer group, and increasing their understanding of the interface between theology and the behavioral sciences. This is accomplished through seminars, papers, critiques of observation interviews between chaplain and patient, weekly logs, and interpersonal growth groups. At the conclusion of the two basic units, the chaplain's progess is reviewed by a committee composed of the chaplain's supervisor and other CPE supervisors chosen by the chaplain's supervisor. This review serves to assess the chaplain's work and to make recommendations for future training needs. If

there is a recommendation to continue in the CPE program, the chaplain will enroll in the two advanced units which provide an opportunity to specialize in an area of pastoral care counseling.

Yale-New Haven's CPE Program At Yale University, LJA conducted interviews with Chaplains Edward Dobinle and Robert Morgan. They coordinate the Army chaplains engaged in the CPE program at the Yale-New Haven Hospital; Chaplain Morgan has direct supervisory responsibility for the Army chaplains. Through discussion, LJA was able to determine the unique and common (to Walter Reed and to other non-hospital Army CPE programs) aspects of the Yale CPE program.

Once the chaplains arrive at Yale-New Haven Hospital they are subjected to a week of processing procedures. Then, in the morning, over a five week period, the chaplains operate as "patient support service aides." Their duties include: transporting patients via wheelchairs or beds, weighing patients, walking patients, and similar activities. The chaplains perform these duties dressed in hospital uniforms sans their clerical garb and other identifying paraphernalia. This affords the first opportunity, in five, ten or fifteen years, that many of these chaplains have had to be related to as people, rather than as clergy. During this period, the chaplains are able to explore their personal and professional selves. These explorations are discussed in afternoon sessions attended by the chaplains and their supervisor. After this group session, there is a didactic session which tries to marry the clinical and theological aspects of pastoral care and counseling.

At the end of this five week experience, the chaplains return to their clerical role and are each assigned an area in the hospital where they will be responsible for ministering to the patients. As there is little imposed role-structure, the chaplains must define their roles within the

hospital. The supervisor conducts individual supervision sessions with the chaplains to assess, evaluate, and critique their role-development. This process is aided by the chaplains, once a week, presenting tapes of their interview sessions with patients, and also through discussion of the written reflections that each chaplain makes of the activities of the past week. These sessions are augmented by two didactic courses in which the chaplains are enrolled over the course of the year: "Theological Reflections" and "Health Care Systems--Implications for Medicine." (The chaplains may also take additional courses at the Yale Divinity School to supplement their professional development and these courses could lead to completing the requirements for an STM degree.)

The chaplains' tenure at Yale-New Haven Hospital is divided into four quarters with the standard mid-year evaluation conducted at the end of the second quarter. Unique to Yale-New Haven is that each quarter has an evaluation which includes the chaplains critiquing each other.

Throughout the year the chaplains are faced with two issues they are to resolve: the issue of identity and the issue of authority. The issue of identity is tackled first when the chaplains become service aides during their first five weeks at Yale. The issue of authority, while alluded to during the five week experience, is addressed more fully when the chaplains are assigned to minister within a hospital area. Given no imposed direction (which is contrary to the experience these chaplains have had in the Army), the authority of the chaplain's role must be established within a non-structured environment. The Yale experience tries to help the chaplains embrace the issue of authority and understand it. To these ends, the chaplains are confronted with questions and situations which help them identify their

personal and professional roles. It is by confronting and resolving the issues of identity and authority that the chaplains are best prepared to conduct pastoral counseling with their patients.

Walter Reed Army Medical Center At Walter Reed Army Medical Center, CJA staff conducted interviews with Chaplains Jesse Moore, T. Richard Denson, and Raymond Stephens. Chaplain Denson is the CPE supervisor at the Walter Reed Army Medical Center and, as such, the body of this report will concentrate on his efforts. As, however, Chaplains Moore and Stephens are both involved in activities germane to psychogenic diseases and because the chaplains in CPE training at Walter Reed are affected by these activities, comments shall be made on their work also.

Chaplain Denson has oriented the CPE program to reflect Walter Reed's health care team organizational structure. The chaplains are introduced, upon their arrival for training, to many of the health care team professions via an orientation week of seminars conducted by members of the various disciplines. For example: the Chief of Surgeons explains surgical procedures; the Head Nurse discusses nurses' duties and responsibilities; and the Head of the Social Work Department delineates the social worker's relationship with a patient.

Concurrent with these orientation activities, each chaplain is assigned to an area of the Medical Center where the chaplain is to minister in conjunction with a health care team. This ministry occurs during the afternoon periods, after the conclusion of the morning orientation seminars. After the orientation week, the chaplains participate, on typical mornings, in didactic seminars, interpersonal-relations group discussions, verbatims (verbatims are the chaplain's presentations to the CPE supervisor of verbatim interviews with patients), and discussions of the weekly log of the chaplain's experiences.

During these morning seminar sessions, two topics are empnasized that are germane to the afternoon clinical work: 1) the identity of the chaplain as part of the healing team, and 2) the chaplain's ability to distinguish and appropriately practice pastoral care and pastoral counseling. The chaplain, while being assigned to an area in the Medical Center and to a corresponding health care team, still must establish his/her functional identity within the team. Through the seminars, the relationship between healing and religion is presented, discussed, and debated. This provides the theoretical foundation for the chaplain's role on the health care team. In the interpersonal group discussions, the chaplains' feelings regarding their professional and personal roles are expressed. The verbatims provide the opportunity to address individual initiatives (or lack thereof) for involvement with other health care team members; through discussion of the chaplain's cognitions and emotions, positive participation on the health care team is developed and reinforced.

In the same manner, the differences in approach and in conduct of pastoral care and pastoral counseling are illuminated. Pastoral care involves a short term, supportive relationship between chaplain and patient without an explicit or implicit therapeutic contract between them. Pastoral counseling is a long term therapeutic relationship that involves a contract and more of a client/therapist relationship than a patient/chaplain relationship. The differences between these two practices and their appropriate applications are discussed in the seminars, interpersonal groups, and through verbatims.

Aside from the CPE program, the chaplains are engaged in a ministry to the staff at Walter Reed and are also helping to originate an out-patient ministry; both of these projects are related to the prevention of psychogenic problems and the project's effect, at least informally, the chaplains in CPE training at Walter Reed.

Chaplain Stephens has developed a program "to educate physicians to the point where it would be the norm for them to have patients getting and staying well through the understanding that the patient has participated in his/her own getting sick." By developing an understanding of the etiology of psychogenic diseases, the concept of stress, and the techniques of stress management, Chaplain Stephens has started to help members of the health care team, and other chaplains, become more effective in their administration and ministry to their patients.

Chaplain Moore is one of the guiding forces behind the Wellness Clinic at Walter Reed Army Medical Center. The Wellness Clinic, an out-patient facility, is primarily concerned with preventive medicine techniques. Its goal is to teach patients that they are responsible for their health and to help patients manage their stress appropriately. Through Chaplain Moore's initiatives, chaplains have developed a unique ministry to the Walter Reed community.

The CPE Centers at Yale-New Haven Hospital and at Walter Reed Army Medical Center reflect the unique orientations of each institution. While each program is structured similarly--the broad outline of their CPE program is as other Army CPE centers (cf., Harris & Crick (1975) for a discussion of the CPE program at Fort Benning)--their different orientations provide unique opportunities for a chaplain's growth and development, both professionally and personally. The Walter Reed Army Medical Center's programs are especially relevant to this study as they provide chaplains an opportunity to be exposed to the etiology and management of psychogenic diseases.

The structure of these exemplary programs, particularly the Walter Reed CPE program, provided LJA with much direction in the development of the recommended training program for chaplain ministry related to psychogenic

aspects of illnesses. While the presentation in this report of the suggested course structure and criteria necessarily is in broad-outline form, development of the course proper would benefit greatly by modeling its day-to-day, week-to-week, and phase-to-phase programming in concert with the CPE course structure used at Walter Reed.

The Chaplain's Role on the Healing Team

LJA has conducted a review of literature and held interviews with Army chaplains to delineate the role of chaplains on health care teams administering to patients with psychogenic diseases. The research reported in the literature review, and summarized below, concentrates on civilian chaplains. Interpretation of this literature is augmented by information received from Army chaplains.

The team approach to health care has been evolving over the past 25 years (Kinig, 1975). While the initial impetus for adopting the health care team approach may have been Federal monies available to hospitals from various "war on poverty" programs, the merits of the approach have led hospital administrators to adopt it beyond the availability of outside funding sources (Brown & Roberts, 1974; Bozzone, 1975).

According to Kinig (1975), "a team is a group of individuals who must work together collaboratively and interdependently to accomplish their work tasks at all, or well, or efficiently" (p. 160). For hospitals, the health care team approach is useful because the administration of the patient's total health care needs requires the cooperative effort of varied professions. Although it is inappropriate to specify exactly who should be a member of the health care team, as there are many different team approaches available, some broad categorical groups can be delineated. Siegel (1974) says that a team

should have: 1) technical medical care personnel; 2) managers of complex medical problems, nursing and educational concerns; and 3) personnel available for psychological intervention.

Kent and Svetlik (1974) and Kinig (1975) mention that existing health care teams are put together after the fact (i.e., the personnel are not trained to work together). As such, typically there is a certain tension between members of these health care teams. Pihl and Spiers (1977) have shown that there are vast personality differences, by discipline, for the professionals involved with health care teams. These differences "raise serious questions as to the validity of the team approach" (p.272). However, Kent and Svetlik (1974) and Kinig (1975) both suggest that current knowledge in group dynamics offers training directions for progressive health care team development. These authors offer different methods and suggestions regarding how to approach team building and how to minimize potential conflict.

The health care team is a wholistic approach (discussed further beginning with page 20) emphasizing the patient's total health care needs rather than just treatment of the disease or illness in question (Shorten, 1975). Thus, the patient's care includes not only diagnosis and treatment of the illness, but also rehabilitation and instructions on how to stay well. This is especially necessary for patients with psychogenic diseases. For example, Hindi's (1974) research review suggests that to ignore the emotional/psychological causes of asthma and only to treat its physical effects is to ignore the whole disease. She points out that to administer effectively to the whole disease the team approach is essential. Psychiatric care is also done productively and efficiently under the team approach (Brown & Roberts, 1974).

As religion is an important dimension in the healing process for many patients, chaplains are often included as members of health care teams. Ninety percent of the patients surveyed in selected Canadian hospitals thought that religion was an important aspect in helping them overcome their sickness (Daoust, 1977). Daoust found that patients believed that there must be someone on the healing team to minister to a patient's spiritual needs. In that vein, studies have found that the hospital chaplain is considered by patients to be an integral member of the healing team (Neels, 1977). Daoust (1977) found that other members of the healing team (doctors, nurses, orderlies, etc.) believed that a qualified chaplain has a role to play on a healing team, not only as a minister to the patient, but also as a professional consultant to other healing team members.

The chaplain's role on the healing team is unique. She/he is the only member whose professional charge emphasizes that the patient is a whole person. Other disciplines assess the patient from their unique perspective and only by combining the perspectives can a more complete picture of the patient be derived. The chaplain must take into account the whole patient to adequately minister to him/her.

The literature offers some directions to be considered regarding the chaplain's duties on the healing team. McKeachie (1977) studied the "unique role of the chaplain" over a nine month period at the Toronto General Hospital. By studying patients, their families, and other medical personnel, she determined that each group saw the chaplain's main role as giving comfort. Chaplain's (1977) study of patients in Waikato Hospital in Hamilton, New Zealand, indicated that while there was a positive endorsement for the chaplain's role as a minister to the patient's spiritual needs, the strongest affirmation was for the chaplain to be an understanding and good listener.

Chaplain (1977), McKeachie (1977), and Posavac and Hartung (1977), all seem to indicate that the spiritual atmosphere the chaplain provides is more important than his/her specific religious indoctrination. For example, Posavac and Hartung studied those persons who preferred to have therapy conducted by chaplains rather than a psychiatrist or other mental health personnel. They found that people who prefer counseling done by ministers expect the same services that they would receive from any other psychotherapist. The clients selected ministers because they preferred a spiritual orientation in their counselors. The chaplain's presence is apparently desired for his/her spiritual connotations.

The foregoing literature review suggests a role for chaplains as supportive of patient's therapy. This role emphasizes the ecumenical connotations of religious figures; an almost secular posture of a counselor in clerical garb. While that role appears to be helpful some patients, it does not recognize the denotative potentialities of chaplains. Although there are other representations throughout the Army, the Walter Reed Army Medical Center chaplains offer a fuller embodiement of chaplains' potential to minister not only to patients but also to the entire Medical Center community.

The individual contributions of Chaplains Moore, Stephens, and Denson have been presented in the previous section; reiteration is not needed. It is, however, necessary to state that their unique ministries are carried through with the assistance of all the Walter Reed chaplains. This collective ministry is diverse and active and not stereotypic and limiting as recorded within the presented literature.

As previously mentioned, the Army is a unique and ubiquitous system, whose effects, of course, must be taken into account regarding the wellbeing of its members. Like any system, its effects can either promote or retard its

community's health. With cognizance and sensitivity, the Walter Reed chaplains have developed their ministry to meet the unique needs of their environment. This has included a spiritual ministry to patients, an educational relationship with the Walter Reed staff community, an orientation towards sharing with patients stress-management techniques, and a concern with emphasizing perspectives for healthy wellbeing.

Extrapolating from the psycho-spiritual ministry which the Walter Reed chaplains and others have evolved, LJA has developed suggestions for the structure and criteria of a training program that would maximize the chaplains psycho-spiritual ministry to patients with psychogenic diseases. This course, a marriage of spiritual healing and stress management, prepares chaplains for their role as the sole healing team member responsible for the physical, mental and spiritual health of patients: the whole person.

CHAPTER II. A TRAINING PROGRAM FOR CHAPLAINS: "PSYCHOGENIC DISEASES: THEIR ETIOLOGY AND PSYCHO-SPIRITUAL MANAGEMENT"

The training program entitled "Psychogenic Diseases: Their Etiology and Psycho-Spiritual Management" is designed to help chaplains become more aware of psychogenic diseases and how the chaplain can better help the afflicted manage their illness. The proposed program is projected to take one year to complete and would be best conducted at an Army Medical Center.

There are two phases to the recommended training program. In Phase I, the chaplain-trainees would experience didactics, training, and group discussion sessions. During Phase II the chaplains would minister in the wards of the Medical Center while having individual and group supervision, and receiving additional training, where warranted. Both phases would be coordinated by a multidisciplined training team. Discussion regarding the recommended composition of the training team is presented below.

The Multidisciplined Team

Many persons, both scientist (Kubler-Ross 1969; Pelletier, 1977) and theologian (Oursler 1957; Blades, 1979), have spoken of the need to work in multidisciplined teams when administering to the psychogenically diseased patient. It has become clear that to provide effective diagnosis and treatment many of the traditionally separate health care divisions must work in concert. Army medical centers have embraced this concept, utilizing healing teams in the care of their clientele. However, for any one member of the team to be effective, that member must have working knowledge not only of the other members' roles but also of the language germane to their discipline. In that manner, communication and cooperation can be most effective.

Therefore, the chaplain-trainees should be trained by a multidisciplined team capable of administering to a patient's total health care needs. It is recommended, however, that the team coordinator be a chaplain who has been working in this field, who is familiar with the technical information and procedures to be covered in the training program, and who is also versed in the relevant theology. The chaplain coordinator would have the necessary supervision responsibilities during Phase II of the course and would conduct the group discussion sessions regarding the relevant theological issues during both phases.

Wholistic administration to the psychogenic aspects of patients' diseases represents, a partial departure from the current medical model orientation (discussed further on page 20) of most American universities: it is thus inappropriate to use professional labels to designate members of the multidisciplinary team. It is more appropriate to designate the proficiences that the members should have, adding that they generally should also have the terminal degrees in their professional field (i.e., Ph.D., M.D., R.N., D.V.M., M.S.W.) as well as at least several years of practical experience. The following is a list of proficiencies that should be represented on the team.

1) Proficient in the physiology of stress and its relation to psychogenic diseases.
2) Proficient in the socio-psychology of stress and its relation to psychogenic diseases.
3) Proficient in training regarding the stress management modalities.
4) Proficient in the issues surrounding and modalities of spiritual healing and psychogenic diseases.

While there are persons who can claim proficiency in more than one of the above areas (indeed, multi-proficiency would be desirable for team membership), LJA considers it appropriate that the team be composed of four members (inclusive of the supervisory chaplain) who will each be responsible for one proficiency area. In this manner, the teamwork concept will be reinforced to the chaplain-trainees.

The training program would be most effectively conducted on the grounds of an Army medical center. Although, Phase I does not require the clinical work for the chaplain-trainees that Phase II does, LJA believes that physical attendance at a Medical Center will immerse the trainees in the milieu of the hospital which, despite some detriments, will be stimulating for them. Attendance on the grounds of a Medical Center will also afford the teaching team with access to real-life examples, where applicable, for their classes and verbatims.

Phase I

Phase I is proposed to last four months. During this phase, the chaplain-trainees would be exposed to lectures, experiential training in stress-management techniques, and discussion group sessions on theological issues. The chaplain-trainees would become acquainted with the concept of stress, stress-management, the etiology of psychogenic diseases, and the relevant theological issues. Phase I would provide the chaplains with the foundation needed to initiate the clinical work required of Phase II. To elucidate the Phase I issues, the following discussion is organized by training mode and presents the subject focus and orientation for that mode.

Lectures

Without previous involvement in stress-management activities, it is unlikely that chaplains will be familiar with the vast literature that the field has produced. To embrace the stress-management training and to be able to communicate adequately with other professionals in the field, LJA recommends that the chaplain-trainees receive lectures on the physiology of the human body, the specific physiological reactions of the body to stress, the socio-psychological reactions to stress, and the manifestation of stress as a psychogenic disease. A short presentation of these lecture topics presents the orientation that LJA suggests for them.

The Medical Model Prior to and during the 1800's, infectious diseases, like malaria, tuberculosis, and polio, were at epidemic proportions, ravaging western society. With the advent of vaccines, better counseling regarding prenatal care, and the advances in medical technology, many of these diseases either have been controlled or functionally eliminated; however, during this eighty year period, the death rate has not been affected significantly by

these actions. While infectious diseases have had a declining effect on the death rate, stress-related diseases have accounted for an increasing effect. Aside from life-threatening stress-related diseases, like heart failure, cancer, and strokes, there also has been a general increase in other stress-related diseases of somewhat lesser catastrophic impact: ulcers, colitis, asthma, hypertension, headaches, sexual dysfunctions, insomnia, and a range of neurotic and psychotic malfunctions. Because of the shift in disease etiology from infectious diseases to stress-related diseases, many health care professionals have advocated a reassessment of the medical model of disease treatment.

The medical model approach to disease treatment emphasizes the specific cause-effect relations of an agent (micro-organisms) to a host (people) within the host's environment (home, workplace, etc.). While acknowledging the potential multiplicity of causes for a disease, medical theory and research has primarily focused on external physical agents of diseases (i.e., micro-organisms), their identification and subsequent control. This approach, distinguished at the turn of the century from religious and magical practices, has produced many insights and discoveries regarding the identification and eradication of many life-threatening infectious disease. The medical model, buttressed with the breakthroughs of discovering specific disease microbes, flourished and brought with it an increasing specialization in the health care field. Medical specialists currently attempt further to dissect and isolate the external causes for diseases.

A major result of these actions has led to a deemphasis on the personality, social, and religious aspects of healing that were once of principal concern. Healing, once under the control of the church and thought to emanate from God, became the province of medical science, searching for micro-organisms rather than salvation. (The role of the church in healing

will be discussed further in the "Discussion Group Sessions" section of this report.) In fact, most physicians, prior to the advent of the medical model, readily acknowledged the reality of the influence of the personality on the body in disease occurence and recovery. Simonton, Matthew-Simonton, and Creighton (1978) extensively quote many fathers of modern medicine, Galen, Burrows, Walshe, Bernard, Snow, and others, who have discussed the effects of emotions on the development or curability of cancer. These men emphasized the folly of separating or dichotomizing the mind and body. Simonton, et al., suggest that with the development and growth of psychology as a separate discipline, physicians have responded less to personality issues, concentrating their efforts on searching for physical causes of physical diseases: the medical model.

(The intent here is not to belittle the medical model, for it has produced impressive insights and results. The point is to identify those aspects of disease etiology for which the model can not adequately account, review them, and point out models which better explain the phenomena.)

Even while the medical model was becoming the prevailing doctrine in the field, there were many who questioned the extreme emphasis placed on the agent of the disease as opposed to the host. Even Pasteur, whose work with micro-organisms helped pioneer the medical model approach, suggested that the emphasis was incorrect. Lamont (1974) reports that when Pasteur was on his death bed he remarked that the French physiologist Claude Bernard "... was right. The microbe is nothing. The terrain is everything, (p.23)." Claude Bernard said that when diagnosing illness the person's state of being is of more concern than an infectious organism, per se. He wrote: "The constancy of the internal milieu is the essential condition of free life" (Lamont, 1974; p.23).

Bernard's work and the pioneering works of Cannon, Selye, and others, put emphasis on the host, the internal milieu, the person. Their work cast doubt on the disease etiology account posited by the medical profession: 1) a specific disease is caused when its agent comes in contact with a host; 2) when an agent is identified, isolated, and a cure is derived, its effects (i.e., the disease) can be rid from the host; 3) that prevention (i.e., immunization and other such actions) occurs when a host has been prepared to ward off the effects of an agent; and 4) health is the absence of disease and disease symptoms. These statements are being questioned and qualified with a new emphasis in disease etiology on the whole person; this emphasis is concretized in the wholistic model of disease etiology. This model emphasizes wellbeing as its goal rather than just avoidance of disease. In that pursuit, the multi-dimensionality of people is accounted for, assessed, and orientations and plans for maximizing an individual's positive development are developed by coordinated health teams. The development of this wholistic model has been spurred by the development of and research on the concept of stress. A delineation of the stress concept and its ramifications is presented below.

Stress and its Relation to Psychogenic Disease Hans Selye (1974), who conceived the stress concept, was influenced by the works of Bernard and Cannon, both of whom emphasized the importance of maintaining physiological constancies in body functioning. With their work as a foundation, and based upon his own clinical observations and laboratory experiments, Selye postulated a "non-specific response of the body to any demand made upon it"; this, he called stress. (Selye's lay definition for stress is "the amount of wear and tear within the body." This definition will be easier to use during the socio-psychological lectures on stress.)

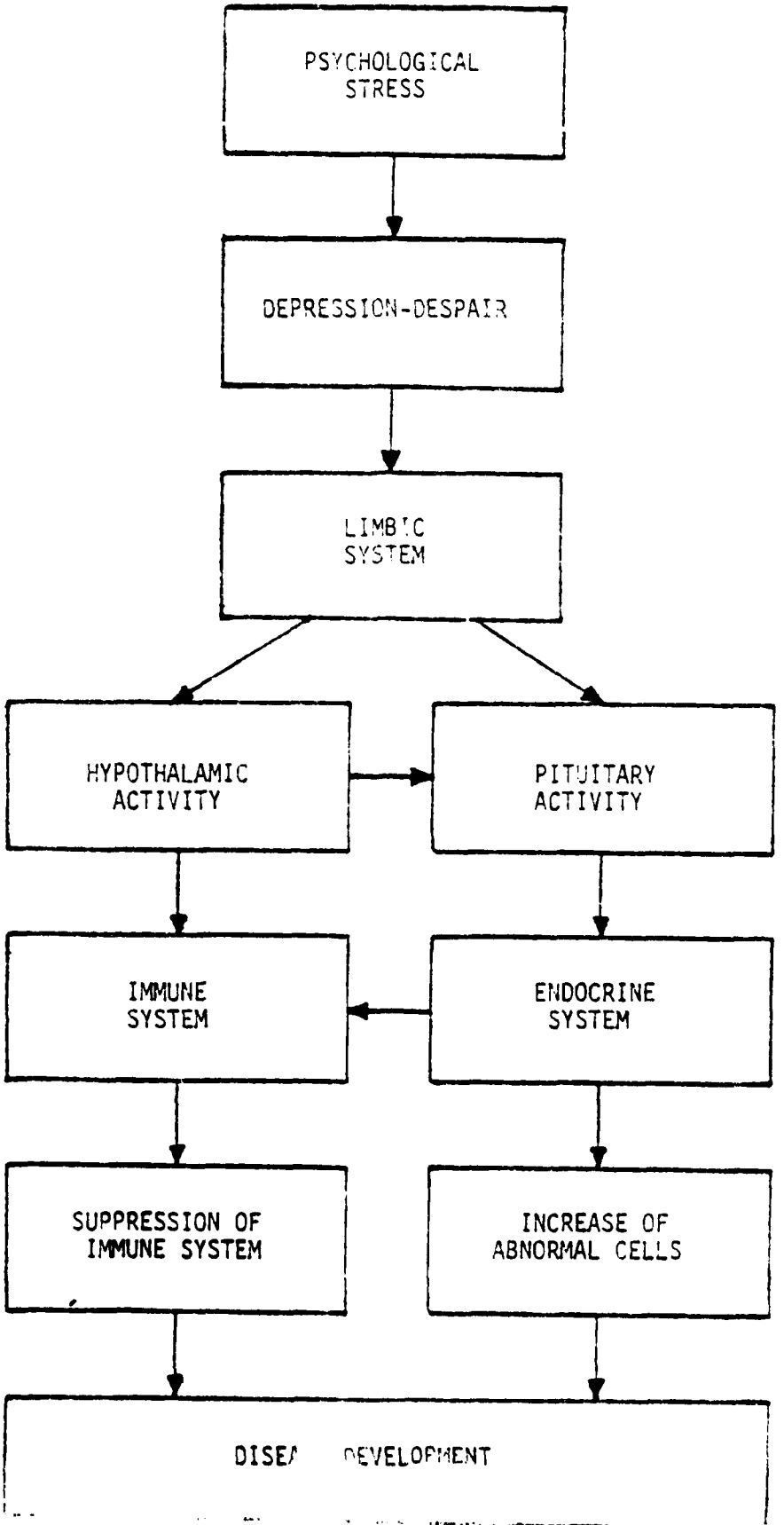
The initial animal experiments that led Selye to postulate the stress concept were conducted under the medical model approach as he was trying to determine specific bodily reactions to various toxic injections. What Selye discovered was that, regardless of the toxic preparation, the animals manifested a general physiological response. Further experiments illustrated that "cold, heat, infection, trauma, hemmorrhage, nervous irritation, and many other stimuli" all produced the same glandular responses in the animals. This suggested that any stimuli that upsets the body's constancy, or homeostasis, would produce, along with its specific effects, a non-specific physiological response. This non-specificity was at variance with medical model thinking.

Selye charted the effects of stressors on the body and labeled the reaction of the body the general adaptation syndrome (GAS). There are three stages to the GAS: 1) the alarm reaction, 2) the stage of resistance, and 3) the stage of exhaustion. Once the effects of a stressor are registered, the brain sends out an alarm to the appropriate organs to combat it. When the organs are "notified" the body's defenses are mobilized to resist the effects of the stressor. During the resistance stage, the general resistance of the body is lowered as energy and efforts are centralized to combat the stressor. Exhaustion implies that the organ or process that has combated the stressor has worn out or broken down. With exhaustion, the body will mobilize other organs, or processes, to combat the stressor, starting the GAS anew until the stressor is no longer viable or the organism dies.

This GAS process is explainable in biological terms. Simonton, et al., (1978) present a figurative representation of the processes (See Figure 1). Their figure has been modified to represent general disease occurrence, broadening their representation of the component flow that leads to cancer development. Figure 1 evidences the exogenous role that stress plays in this etiologic model.

FIGURE 1

MIND/BODY MODEL OF DISEASE DEVELOPMENT



"Of primary importance in terms of stress is the fact that the hypothalamus clearly seems to respond to emotional/psychological stimuli from the limbic system and to intellectually perceived stress stimuli from the cortex" (Pelletier, 1977; p. 33). Among other activities, the hypothalmus simultaneously activates the autonomic nervous system and the pituitary gland which activates the endocrine system. The autonomic nervous system is in control of the body's involuntary nervous system: those bodily activities such as the digestive, respiratory, and vascular functions which were once thought to be unavailable to conscious control. The autonomic nervous system works through two dialectical systems, the sympathetic and parasympathetic nervous systems. The sympathetic system activates and tenses bodily functions, while activation of the parasympathetic relieves and relaxes those same bodily functions. Thus, when a stressor is registered in the limbic system, it activates the hypothalmus. In turn, the autonomic nervous system is notified via the hypothalmus which then activates the sympathetic nervous system to prepare the body to fight or flee the stressor. Pelletier (1977) lists a number of bodily characteristics that are evident when the sympathetic system is activated: "dilated pupils; tight throat; a tense neck and upper back, with the shoulders raised up; shallow respiration; a locked diaphram"; and others. As noted, these characteristics replicate human and animal behavior when in the fight or flight state. When faced with a hostile stressor, the body will react to it and prepare itself for a defense of an escape. When the stressor has been resolved, the autonomic nervous system will activate the parasympathetic system which will reverse all the activated functions and relax the body.

Almost simultaneous actions are occuring in the endocrine system, as the autonomic nervous system is activating the sympathetic system. The endocrine

system is comprised of a number of glands, among which are the thyroid and the pituitary. When the hypothalmus registers the effects of a stressor on the body, it activates the pituitary gland (among other glands, but research has demonstrated that this is a singularly important relation to the stress reaction) which releases adrenocorticotrophic hormone (ACTH) into the blood stream which, in turn, acts upon the adrenal glands. When the adrenal glands are stimulated by ACTH, they secrete corticoids. These corticoids encourage thymus shrinkage, inhibit inflammatory reactions, and stimulate blood sugar productions. Both the endocrine and the autonomic nervous system stimulate the body's glands and muscles to prepare itself for a stressor and to be able to use energy to fight or flee from the effects of a stressor.

Excessive stress effects the body's immune responses. The body's antibody production is supervised by the thymus which, as mentioned, is involved in the stress response. The antibody production is suppressed when the thymus is under constant stress and, as such, the body's ability to combat disease is lessened (Pelletier, 1977; Simonton, et al., 1978). Severe, excessive, and constant stress, which the body cannot manage effectively, weakens the body's antibiotic defense system, rendering it susceptible to disease. It is not stress, per se, but excessive unresolved stress that is potentially harmful to the body.

While excessive stress renders the body susceptible to "external" diseases by altering the homeostasis of the body and creating hormonal and glandular imbalances, stress also creates disorders of its own. Selye (1979) suggests that when the body is under constant stress its weakest genetic component, interacting with environmental factors, will break down, followed by the next weakest, and so on. Therefore, the body, under excessive stress, can either create its own dysfunctioning or become susceptible to invasion from external

agents. It is clear how Selye, the Simontons, Pelletier, and others can consider virtually all diseases as having a psychogenic component.

Although the G.A.S. process is a genetic reaction that, in the past, has served human beings well against damaging stressors in the environment, current Western society (and the Army as a component) has created stress-provoking situations that are not amenable to the fight or flight response. Purely physical dangers or aggressions that once plagued humanity have generally been eliminated or occur so infrequently as to be of little consequence. The aggressions that Western people face are primarily socio-psychological. For example, when a worker is faced with a boss' unjustifiably hostile reaction to a legitimate request for a raise, it is inappropriate in today's Western society for that worker to fight the boss or flee the situation. That is, however, exactly what the body will prepare to do; as the body perceives a threat to its wellbeing, its genetic responses are mobilized. These genetic responses have become socially unacceptable; the worker potentially could lose the job if either of the two alternatives were taken. The body, then, is under stress that it is unable to resolve directly and, as was alluded to previously, under constant circumstances in that vein, it will exhaust itself, necessitating a continual restart of the G.A.S. process until the stressor is resolved or removed or the body is exhausted.

With continued replication of socio-psychological situations that create stress that the body is unable to resolve, the body will stay in a constant state of stress. It is appropriate to point out that the same response patterns will occur when the body is responding to purely physical stessors as: constant pollution, over-crowding, over-exposure to radiation, high noise levels, extreme shifts of temperature, etc. Therefore, the foregoing discussion is equally germane to both physical and socio-psychological stressors.

Stress and Diseases To this point, the discusssion has concentrated on the role of stress in disease occurrence. Stress plays an equally important role in the recovery from psychogenic diseases. By understanding the role of stress as an exogenous variable as portrayed in Figure 1, the potential impact that stress can have in inhibiting the therapeutic process is clear. If the stress that resulted in the disease occurrence is not arrested or abated, then the recovery from the disease will be either incomplete or negligible. Chaplains must embrace this crucial point since the majority of people they will minister to will be in the recovery stage at a Medical Center. The majority of chaplains probably will have only minimal opportunity to effectuate as much preventative intervention as they might like; nevertheless, the proposed training program would prepare them for preventive practice. The Wellness Center at Walter Reed Army Medical Center, mentioned in Chapter I, is an example of the usage of these concepts on a preventative level.

Pelletier (1977) suggests that it is counterproductive to try to link a specific stressor with a specific disorder. It is more profitable to survey human responses to stress, in general, and try to determine any patterns that may emerge. Although the effects of stress are non-specific, the effects of hormones are genetically and environmentally determined. To survey these reactions, many researchers have looked at patients who have certain types of psychogenic diseases and the researchers have tried to identify common behavior patterns that the respective psychogenically diseased patients exhibit. Pelletier (1977) and Lamont (1974) chronicle some of that work. Some of the pioneers in this field include: Lawrence LeShan who has worked with cancer patients for the past twenty years; Carl and Stephanie Simonton, who head the Cancer Counseling and Research Center in Fort Worth, Texas; Meyer

Friedman and Ray Rosenman who have developed the typologies of Type A and Type B behavior and their relation to cardiovascular disease. A brief review of the efforts of these pioneers follows to illustrate the current state of the art.

Cancer and Stress-LeShan LeShan (1974) studied cancer patients via psychological measures, indepth interviews, and analysis. From these sources, LeShan noted four factors that were more prevalent in cancer patients than in non-cancer patients. One was the loss of a central relationship. This relationship could be a person, a group, or an ideal in which the patient had invested so much self that when it was no longer ongoing the patient felt as if life was no longer meaningful and worth living. The second factor was the inability of the patient to express anger or become aggressive in relation to his/her own needs. LeShan found that these people could express anger in response to ideals or infringements on other people's rights but were unable to be hostile in their own behalf. A third factor was self-hate and self-distrust; a particular inability to see any positive attributes in self. A fourth factor was a perceived emotional tension regarding the death of a parent. This last factor, however, later proved to be less significant than originally thought.

LeShan summarized the effects of these factors as manifestations of an underlying trait of despair. This despair is believed to have been a contributing factor to the onset of the cancer rather than as a result of contracting cancer. Despair is marked by feelings of hopelessness in the present and future to bring about constructive changes in the patient's life. The patient believes that as nothing can be done to change the present situation there is no potential for positive development and, as such, feels helpless to take any constructive actions for change.

The despairing patient feels alienated and unable to relate to people or express emotion in a meaningful manner. There is a clear difference between depressed patients and patients in despair. Depressed patients do nothing and give up on life; these patients can be mobilized to attack their problems and embrace life again. Patients in despair follow their daily routines believing that life has given up on them; these patients must be given hope to find meaning in self and existence.

To assess the validity of this despair causation, LeShan tested hypotheses looking at epidemiological data on the rate of cancer for persons of different marital status. The data confirmed his hypothesis that those persons who had lost their love relations (e.g., spouse) and had no available substitute relationships (e.g., children) would contract cancer more often than those persons who were not in those categories. Other hypotheses, regarding the incidences of cancer during wartime in countries experiencing intra-conflict and compared with those which were not, and cancer patterns exhibited for differing generations of immigrating families, also were confirmed.

Cancer and Stress-The Simontons Carl and Stephanie Simonton (Simonton, et. al., 1978) assert in the beginning and throughout their book Getting Well Again that people must take responsibility for their own health and illness. Carl, an oncologist, and Stephanie, a psychotherapist, have worked with cancer patients for over ten years attempting to delineate the mind/body interaction in cancer occurence. At their Fort Worth Center, they have accepted patients pronounced medically incurable by other physicians with prognosis of less than one year to live. With their unique mixture of psychological and medical techniques, their living patients have lived two times longer than they would have under just medical treatment, and of those patients who have died, they have lived one and a half times longer than a control group of cancer

patients. The Simontons also have indications that the quality of life for their patients has been superior compared to patients receiving only medically treatment.

The Simontons say that patients must actively assist in the process of recovery. By using counseling, muscle relaxation, and visual imagery techniques (to be explained in the "Training" section) with orthodox medical cancer treatments, the Simontons have developed a therapy emphasizing an active rather than a passive patient.

Like LeShan, the Simontons point out certain characteristics seemingly common to most cancer patients. The overlap between their typology and LeShan's is apparent. The Simontons suggest that in childhood, certain stressful experiences for these patients resulted in the development of behavior patterns that represent uncompromising reactions to stress. These behavior patterns are primarily unconscious and most people rarely see the links of their current adult behaviors with their childhood decisions. In adulthood, a series of stressful events may occur within a short period of time creating situations which the person cannot successfully resolve primarily due to the rigid behavior patterns emanating from childhood. The individual attempts in some manner of willful ignorance to put distance in between themselves and the stressful events. The Simontons indicate that this process puts excessive and constant stress on the individual, deleteriously effecting the body's immune system, allowing the cancer to develop. The emphasis here clearly indicates the role psychosocial stressors play in allowing cancer cells to develop and multiply; and the distinction between allowing a disease to develop and causing one is a critical one.

Through the therapeutic and intervention techniques previously mentioned, patients at the Center are encouraged to explore the behavioral patterns that

allowed the cancer to develop and spread. The broad based program also includes advice on exercise, diet, family counseling, and counseling on death and dying.

Heart Attacks and Stress-Friedman and Roseman Friedman and Rosenman (1974), in the late 1950's were dissatisfied with the litany of supposed causes of heart attacks that neither singularly nor collectively were compelling. In search for alternative explanations, they received direction from two sources: an upholsterer who had noticed that the edges of patients' chairs in the doctors' offices were worn away as if someone were gripping or sitting on the edge of them, and from a wife, who remarked that her husband's heart attack was due to job stress. These insights led Friedman and Rosenman to study the behavioral characteristics of individuals with and individuals susceptible to cardiovascular diseases. After studying thousands of men and conducting numerous animal studies, Friedman and Rosenman were able to distinguish two behavioral typologies that they classified as Type A, susceptible to heart attacks, and as Type B, not susceptible to heart attacks.

The Type A man has "a habitual sense of time urgency or 'hurry sickness'." The Type A person continually feels rushed for time, is continually struggling to meet deadlines, and tries to accomplish more and more in less and less time. This leads the Type A person to engage in polyphasic behavior--doing two or more things at one time--continually. The Type A person also has a quest for numbers. Regardless of profession, the Type A person measures his worth by trying to produce more and more. While the Type A man exudes security, in reality he is very insecure. This is manifest in his incessant desire to please his superiors even if it means ignoring camaraderie or congenial relations with his peers or inferiors. The

Type A man's aggression and nostility are most clearly manifested when in competition with another Type A personality; Type A men snow little aggression to Type Bs.

A Type B man does not have any of the above traits and is distinguished particularly by his ability to relax and play appropriately. The interesting thing about a Type A as compared to a Type B is that there are no differences between them on success indices: ambition, stature, money, acquisition of material goods, etc. Type A men do tend to have higher serum cholestrol and higher serum fat, smoke more cigarettes, exercise less, eat more meats rich in cholesterol and animal fat, and have higher blood pressure than do their counterpart Type B men. The striving of the Type A men seems to interact with a host of factors to cause heart attacks. Freidman and Rosenman, however, make it clear that it is the striving that they consider to be the root cause of the disorder.

The works of LeShan, the Simontons, and Friedman and Roseman on specific phychogenic diseases and the respective behavioral patterns those afflicted with them exhibit, make clear the relation between constant, excessive, unmanaged stress and the body's breakdown.

Life Events and Stress Two groups of researchers, Holmes and Rahe (1967) and Johnson and Sarason (1978) have studied the relation between disease occurrence and total number and type of social stressors accumulated over a period of time. For this discussion, it is timely to recall Selye's (1974) lay definition of stress: the wear and tear on the body of daily life events.

Life Events and Stress: Holmes & Rahe By studying many diverse subjects, Holmes and Rahe constructed the Schedule of Recent Experiences (SRE); fifty-two life events that were assigned values between 1-100, indicative of their relative stress effects. A person checks the number of life events that

have occurred in the last twelve months of that person's life. The values for these events are then summed and that score indicates the relative chance that person has for having a major illness occur in the next twelve months. If the summed score is over 150 points then that person has a 50% chance and if the person has a score of 300 or above then there is an 80% chance.

The SRE offers weight to the conclusions of Selye and others, like Vaillent (1977): it is not the singular traumatic stressor that is most important but it is the sheer number of stressors that tends to have the most damaging effect on the body. Some effective work is starting to be done using the SRE as a diagnostic tool, mitigating against the effects of stress.

Life Events and Stress: Johnson & Sarason In an extension of the work done by Holmes and Rahe, Johnson and Sarason (1978) have modified the SRE and broadened its theoretical underpinnings. Johnson and Sarason argue that negative events exert a larger stressful impact on an individual than do positive events, while the SRE does not differentiate that potential. An example would be the item "Major change in financial status." Johnson and Sarason argue that this could be as different as bankruptcy or a major inheritance and that regardless of which, it is the individual's interpretation of the negativeness or positiveness of the event that is crucial to understanding the potential stressful impact.

With these and other concerns, Johnson and Sarason adapted the SRE and developed a new measure, the Life Experience Survey (LES). Testing the LES and SRE, the investigators found the LES to be a better predictor of illness occurrence than the SRE. This type of research indicates the growth and development of the measurement area of the stress research field.

Summary Regarding Lectures The above brief discussion on stress, its components, and its manifestation in psychogenic diseases are the types of content areas that the lectures should embrace. The chaplain-trainees must embrace not only the technical data on stress but, perhaps more crucially, be attuned to how humans are viewed via these conceptualizations. The wholistic view that this perspective requires must be compatible with the chaplain-trainees views; a theme to be discussed further in the "Discussion Groups Sessions."

LJA also hopes that the point is made about the vast amount of information that the chaplain-trainees will have to embrace for successful completion of the course. To aid the chaplains in their pursuit, LJA recommends that a programmmed learning and/or programmed learning computer tape (where facilities permit such) be developed to help to teach the chaplains about the body's physiological functionings, psycho-social stress, and the effects of stress on the body.

An example of a programmed learning text is F.J. McGuigan's Biological Basis of Behavior: A Program, a time efficient and material sufficient way to embrace basic knowledge regarding a subject area. The programmed learning text and computer program methods are proven techniques for teaching or acquainting a student in a short period of time with basic knowledge in a subject area. (The Army, in point of fact, has been in the forefront of developing the educational and computer technology for these types of learning formats.) With the programmed text providing basic knowledge and relations, the lectures could clearly delineate specific nuances of the relationship between stress, the body, and psychogenic diseases.

Experiential Training in Stress-Management Techniques

Selye (1974) declares that stress, in and of itself, cannot and should not be avoided, for without it there would be no life. There is an optimal level of stress under which each person is stimulated and this level is to be sought. However, continued stress, especially negative stress (Johnson & Sarason, 1978), must be resolved to lessen its potential for damage. There are many modes available to help patients mitigate or prevent the deleterious effects of continued stress. The stress-management modes recommended for presentation to the chaplain-trainees represent a potpourri of the currently advocated techniques.

The techniques presented in this section will be accompanied by examples indicating their usage in the recovery from diseases. These techniques are adaptable to usage in the preventative vein and their flexibility is discussed.

It is important for the chaplain-trainees to be able to discuss in some depth the applicability and appropriateness of various stress-management modes with patients. Chaplains must be trained in methods of presenting these techniques to patients in such a way as to produce the most favorable impressions of their efficacy. These modes are largely unfamiliar to the general public, including the average soldier, veteran, or dependent. To a large degree, the usefulness of the techniques is partly determined by how convinced the patients are of the efficacy of the mode. This placebo effect is very necessary and desireable and it should be nurtured to derive as much benefit as possible.

Benson (1978), in his book The Mind/Body Effect, devotes much discussion to the placebo benefits for patients by virtue of just the presence of doctors or the availability of treatment; benefits distinguisnable from their real or inherent abilities to cure. Patients derive measureable benefits from

people represented as "healers" or from treatments just by virtue of being exposed to them; they start to feel better just because they have seen a doctor or taken a pill. This placebo effect for chaplains has been confirmed at Walter Reed Army Medical Center by Chaplains Stephens and Moore. They report doctors' observations that patients respond and appear to be better after having just seen a chaplain. It is to the chaplain-trainees benefit that they learn how to nurture this placebo effect in the presentation of stress-management and spiritual healing techniques. Pelletier (1977) in discussing the Simontons work says that Carl Simonton specifically mentions that the single most important factor in a patient's recovery and ability to assist the therapeutic techniques was the patient's attitude. If the attitude towards recovery was good, recovery moved on positively; negative attitudes resulted in a misuse or mistrust of the therapy, often with life-threatening results.

The chaplain-trainees must be aware of the effects that are ascribed to their societal role as a religious figure and how this role impacts on their abilities to use their placebo aura, to teach the stress-management modes, to conduct spiritual healing, and to create positive health habits.

The following summaries will illuminate the effects and uses of each modality. Meditation in all its forms, appears to be preeminant in its effect and use and, as such, will be discussed first. All other modalities are listed in alphabetical order.

Meditation Of all the stress-management techniques, some form of meditation is mentioned consistently across authors and practitioners. Lamont (1974) discusses Zen, Yogi, and Transcendental Meditation (TM); Benson (1975) postulates the "relaxation response"; Mitchell (1979) talks of "simple

relaxation" techniques; Bloomfield and Kory (1979) discuss and compare TM with Samuel and Bennett's "feeling pause," Jacobson's "progressive muscular relaxation," and Benson's relaxation response; and Pelletier (1977) compares alternative forms of classical meditation techniques and modern adaptions of them (such as Jacobson's progressive muscular relaxation) in their efficacy with certain psychogenic diseases. As scientific study on the effect of meditation has increased significantly over the past twenty years, there has been increasing support for the role of meditation as a mitigator against the harmful effects from excessive stress. A brief description of the body's physiological response to meditation is appropriate.

An noted before, when the body is under stress, it responds as if preparing to fight or to flee. The hypothalmus activates the autonomic nervous system which in turn activates the sympathetic system which prepares the body for the fight or flight response. The body becomes susceptible to disease or will create its own if left in this fight or flight state without resolution; often the case in Western society today. With resolution, the parasympathetic system will become active, relaxing the body and restoring a muscular and glandular homeostatic state. Pelletier (1977) discusses research on the effects of meditation and concludes that meditation is able to decrease the sympathetic nervous system arousal and bring about a physiological and psychological state that is opposite of the fight or flight response.

Research indicates that constant meditation has a carry-over effect into daily life suggesting that a meditative state can be a very healthy adaptive response to social stressors that an individual can not fight or flee. Pelletier discusses studies that suggest that meditators are psychologically stable, autonomically stable, less anxious, and have an internal locus of

control. More important to the current project is the effects of meditation as an alleviator of psychogenic illness. Studies have shown that TM has been used successfully to mitigate the effects of asthma, anxiety, hypertension (Pelletier, 1977), and other such psychogenic disorders Benson (1974).

The many meditation practices described at the beginning of this section, although different, share commonalities. And while many advocate the use and guidance of a person trained in meditation to lead an inexperienced person, Lamont (1974) and Benson (1974) suggest that meditation can be learned by the individual alone. The instructions that a yogi would give, replicating the steps an individual would have to take to learn meditation, are paraphrased below.

Initally, find a quiet place (Lamont suggests that after the practice has been mastered, a person can meditate anywhere). Select a mantra: this is a meaningless syllable that a yogi or TM leader would provide as that person's supreme mystic phrase. (In reality, a person can repeat the phrase Om, Shom, Ayn, or even "one," as Benson suggest. Some researchers, however, suggest pitfalls in using any syllable or phrase that already has a meaning, suggesting that it might precipitate a stream of consciousness that would interfere with the meditation process.) Postured in a comfortable position, typically sitting with head up, back straight, and feet flat on the floor, a person takes a few deep breath and begins to repeat slowly the mantra, over and over. While many thoughts will flow naturally into conscious awareness, a person is advised to be rid of those thoughts gently by concentrating on the repetition of the mantra. In time, concentration of the mantra will bring a relaxed physiological state and virtual exclusion of extraneous thoughts.

Meditation is said to be most effective when it occurs twice a day for approximately 15 to 30 minutes, preferably before having eaten.

Benson's (1974) research indicates that meditation puts an individual into a deeper relaxation state than is usually attained in normal relaxing or sleeping. Bloomfield and Kory (1977) indicate that the effect of meditation on respiration, heart rate, metabolic rate, oxygen consumption, blood pressure, stress hormone production (e.g., ACTH), and brain wave coherence is the opposite of the effect of constant stress. It is clear that meditation evokes a physiologial reaction that mitigates against the harmful effects of excessive stress.

Autosuggestion As the subject heading " meditation" was used as a catch-all for various types of meditation practices, so is "autosuggestion" used here to refer to a number of states that are effectuated through suggestion: hypnosis, autogenics, and visualization. The similar effects for both autosuggestion and meditation are marked, but there are crucial procedural differences. Both states involve a passive concentration, but autosuggestion involves a more active manipulation of bodily functions than does meditation; however, it seems that their effects are comparable.

The best known autosuggestive state is hyponotism. Procedurally in hypnotism a subject is asked to relax, to become comfortable, and then to focus attention on an object such as a candle, a circular pendulum, or a bright shiny object. (This discussion is guided by Lamont's, 1974, presentation on hypnotism.) Once the subject's eyes appear to tire, the hypnotist talks, trying to induce in the subject a relaxed state, saying "now that you are comfortable, let yourself relax as much as possible. Take a good breath, which helps you relax.....keep your eyes fixed....let your eyes go out of focus....Take another deep breatn...." (Lamont, 1974; p. 121). Once the

patient appears to be in a hypnotic trance, the hypnotist can suggest things to the patient. The use of hypnosis to regress a patient' age in order to resurrect repressed feelings is well documented in the psychiatric literature. The well publicized book Sybil is an example. Lamont (1974) reports the use of hypnosis in aiding patients with psychogenic diseases, such as cardiovascular disease, not only in recalling the crisis that precipitated the disease, but also in receiving instructions on the control of the disease. Lamont also reports on some unique work with hypnotism and acupuncture, and the control of chronic pain and pain during surgery.

Autogenics can be viewed as a self-induced hypnotic state. The subject, first becomes comfortable by sitting or lying down with the eyes closed. The subject then repeats a series of statements designed and ordered to relax various bodily functions. These statements are reported in depth by Pellet (1977). Clinical work done with patients with psychogenic disorders undergoing autogenic training has suggested successful mitigation or resolution of bronchial asthma, constipation, cardiospasm, sleep disorde nocturnal enuresis, anxiety, indigestion, ulcers, colitis, angina pecto nigh blood pressure, hemorrhoids, tuberculosis, diabetes, and low back syndrome (Lamont 1974).

The Simontons have done some of the pioneering work on the use o visualization techniques (sometimes called visual imagery or guided with cancer patients (Simonton, et al., 1978). Visualization proc such: The patient is relaxed through breathing exercises. Once patient is asked to visualize a pleasant scene. After enjoying visualization, the patient is asked to visualize the cancer (or by disease a patient has). The visualization of the cancer can t long as it is the patient's image of it. Then the patient is

patient appears to be in a hypnotic trance, the hypnotist can suggest things to the patient. The use of hypnosis to regress a patient' age in order to resurrect repressed feelings is well documented in the psychiatric literature. The well publicized book Sybil is an example. Lamont (1974) reports the use of hypnosis in aiding patients with psychogenic diseases, such as cardiovascular disease, not only in recalling the crisis that precipitated the disease, but also in receiving instructions on the control of the disease. Lamont also reports on some unique work with hypnotism and acupuncture, and the control of chronic pain and pain during surgery.

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visualize an attack that fells the cancer cell image; this attack is conducted by whatever the treatment is the patient is undergoing: radiation, chemotheraphy, etc. The next visualization is of the body's white blood cells carrying the dead cells through the blood, liver, kidneys, out of the body. Throughout the visualization, the patient is encouraged to maintain a postive attitude towards the treatment and towards the self. The Simontons have reported success using this technique, helping to induce remission in patients with cancers that were regarded as terminal.

Hypnosis, autogenics, and visualization, all attempt to influence bodily functioning. The end effects of these three autosuggestive functionings replicates the effects of meditation although the procedures are different. These activities appear to have an effect on the mitigation and resolution of psychogenic disorders. The next section on biofeedback is, pernaps, another door in the same house.

Biofeedback Pelletier (1977) discusses the conceptual bases for biofeedback and points out three basic principals:

> 1) any neurophysiological or other biological function which can be monitored and amplified by electronic instrumentation and fed back to a person through any one of his five senses can be regulated by that individual; 2) every change in the physiological state is accompanied by an appropriate change in the mental emotional state, conscious or unconscious, and conversely, every change in the mental emotional state, conscious or unconscious is accompanied by an appropriate change in the physiological state; 3) a meditative state of deep relaxation is conducive to tne establishement of voluntary control by allowing the individual to become aware of subliminal imagery, fantasies, and sensations. (p. 265)

Through biofeedback, a patient is able to learn about the functioning of the autonomic nervous system. While once thought to be out of conscious control, the autonomic system is now considered amenable to conscious control - a concept alluded to in the prior discussions on "meditation" and "autosuggestion." Biofeedback teaches the patient how to control specific areas of the body involved with psychogenic diseases. This specific control reinforced with the broader effecting meditative techniques can be a very powerful tool for psychogenic diseased patients.

"By combining training in regulation of specific dysfunctional systems with overall relaxation methods such as autogenic training, meditation, and progressive relaxation, clinicians are creating a model of treatment that can truly be called holistic." (Pelletier, 1977; p. 270.)

Training in biofeedback requires knowledge of physiology, psychogenic diseases and behaviors, and of machines, such as the Galvanic Skin Response (GSR), the electromyograph (EMG), the electrocardiogram (ECG), and the electroencephalograph (EEG). By becoming aware of the body's reactions via the feedback from the machines, people can gain control of the relaxation and activation of bodily functions.

Crisis And Life Style Management Maintaining an appropriate balance of psyche and soma through the use of biofeedback, meditation, and autosuggestion, must be complimented by changes in lifestyle and ability to manage crisis situations. Approaching life wholistically means that a person must take control over internal funcions as well as over external daily interactions with the environment. If a patient with a psychogenic disease undertakes meditation and the other mentioned techniques without readjusting the lifestyle pattern that brought about the disease occurence, then that patient is still following the medical model approach: treating the symptoms,

but not the causes of the disease. Patients with psychogenic diseases must be oriented toward readjusting previous behavioral patterns to accentuate and compliment internal developments that occur with meditation and the other techniques.

The impact and interchange of diet, vitamins, exercise, environmental functions (e.g., pollution), and interpersonal interaction patterns must be brought in concert such that development in one area does not retard or impede development in other areas. There are many books, like Shealy's (1977) 90 Days to Self-Health and Bloomfield and Kory's (1978) Health and Happiness, that offer blueprints for coordinated development of the above factors. There are also a number of texts that cover each specific topic in detail.

The point, however, to be emphasized is that healthy well living is effectuated through a conscious and coordinated plan of activities. It is important to take as many factors into consideration as possible, but it is equally important to realize the individual's unique needs and reactions to these factors. Sensitivity to this individuality must be present so that patients are not squeezed into an already-conceived life-style. Options must be developed around their own unique needs which take into account their past, present, and future development. As the individuality of the stress responses has been noted previously, it is just as important here to note the individuality of the plan for alleviating the effects of stress. Books such as Shealy's and Bloomfield and Kory's are useful guides but must be adapted and used flexibly.

Death and Dying Preparation It is conceivable that the effects of a psychogenic disease may bring about death despite the best effort of the healing team and the patient to ward it off. While the concept and theology of death is to be approached during the discussion group sessions it is

necessary and appropriate for the chaplain-trainees to be aware of how to counsel and prepare patients and family members to accept the inevitability of death.

Although much work is occurring on death counseling, the seminal work in this area was done by Elizabeth Kubler-Ross (1969). Through Kubler-Ross' work, the five adjustment stages of a dying patient have been identified. The first stage emphasizes the denial of the disease and the isolation felt because of it. The second stage is marked by anger. Bargaining with the diety for more time occurs during the brief third stage. The patient is no longer able to deny the illness during the fourth stage, and becomes depressed in two phases: first, reacting to the disease and secondly, preparing for its results. The last stage is characterized by the patient's acceptance of the disease and a preparation for death.

In discussion regarding these five stages, the appropriate counseling and comforting modalities used to aid the patient in accepting the disease and to help the family adjust to the patient's dying and death are presented. This type of training is especially necessary because chaplains are often called to minister to dying patients and their family, and, in the course of any patient's stay at a medical center, aspects of the five stages appear in reaction to many diseases, which, though not life threatening, may result in long term disability.

Summary of Training in Stress-Management Techniques These techniques provide chaplains with effective methods for helping patients with psychogenic diseases take some control and responsibility for their successful recovery. The chaplain's charge is to be responsive to the whole person and these methods, along with the spiritual healing modes to be discussed in the next section, assist chaplains in fulfilling that charge.

Discussion Group Sessions On Theological Issues

The discussion group will be directed by the supervisory chaplain, who would be proficient in the theological issues regarding healing. During these group sessions, discussion will ensue providing a theological foundation for encompassing the broad latitude of behaviors related to spiritual healing.

Bloomfield and Kory (1977), in their discussion of wholistic medicine, include a specific section regarding the spiritual dimension of humans. They conclude that while spirituality is to be considered the glue that holds the body together, there is little scientific attention given to this dimension, apparently because of the inability to quantify spiritualness (cf., Oursler, 1954). Bloomfield and Kory further suggest that many of the crises that precipitate the onset of a psychogenic disease are spiritual, as they reflect questions regarding the meaning of life. Other researchers also allude to the influence of spirituality and its relation to psychogenic diseases and healthy living (cf., Selye, 1974; Benson, 1978).

While scientists have not studied the role of spirituality in the etiology of psychogenic diseases (sans the contributions of Jung), many theologians have, and the debate regarding philosophy and methods that they have generated needs to be addressed by the chaplain-trainees. A consideration of the types of issues that should be discussed is presented below.

Humans as Closed Energy Systems and Dualism The perception of people as a closed system with mutually exclusive bodily functions made, and makes, the acceptence of psychosomatic medicine very difficult for some scientists. Kelsey (1973) points out that philosophers such as Aristole, Kant, Newton, Darwin, Hegel, Locke, Kierkegaard, Husserl, Sartre, Whitehead, and Russel, while having different points of view on many issues, all uphold or accept the notion of dualism, the separation of mind and body within a closed physical

system. The philosophies of these men, which have guided scientific inquiry for centuries, assert the one-way effect of the mind on the body. Not only is reciprocal interaction not considered, there is no consideration of the metaphysical spirit as significant. Philosophers, since Aristotle, have considered human beings as closed physical systems with the mind on a higher, though separate, plane than the body. Traditional Western philosophy has asserted consistently the ability of the mind to control the body through conscious discipline. Any illegitimacies or weaknesses that the body engages in are considered done with conscious approval of the mind. Western society has developed upon this consideration and that influence on the medical system is evident. Medical science has considered the dualism of mind and body to be evidence of scientific progress, breaking away from the influence of magic, superstition, and religion. This will be discussed further in this section.

Kelsey suggests that with the twentieth century and the works of de Chardin, Einstein, Freud, Jung, and others, a gradual debate not only of mind/body effects, but also of the potential for human interaction with metaphysical beings, such as a spirit, was given impetus. Freud especially contributed enormously to the legitimacy of this debate with his conceptualization of the unconscious and its effects on behavior. Only then could scientific debate ensue regarding a fluid interaction between mind and body and, hence, psychosomatic medicine. Still, the parameter of a closed physical system was imposed by many upon the debate: Selye's (1974) work is a good example. He believes that the body is a closed system with a certain amount of adapation energy. The effects of excessive stress are considered to drain the energy supply, making disease and premature death probable.

Jung's work (widely quoted by many theologians in this area) offered the first serious scientific structure for accepting the interactions between spirits and the mind/body. Jung's theories, for the first time since Plato, Jesus, and the early Christian church, considered the body to be an open system. From this, a new hierarchical conception arose emphasizing more fluid interactions. Some theologians and scientists began to consider the spiritual self to be preeminant in its effects over the mind--which is still considered to be dominant in its effects over the body (Oursler, 1957; Theophysical, 1975; Bloomfield and Kory, 1977; Blades, 1979).

Spiritual Healing In The Old Testament Kelsey's (1973) book, Healing and Christianity, explores the Judeo-Christian history of spiritual healing. Sickness in the Old Testament was considered as "God's rebuke for man's sin." For the Jews, if a man was sick he had fallen out of grace with God and was to be avoided by his brethren. Kelsey suggests that the Old Testament portrayed sickness in two ways as a discipline tool. One was to stress the importance of the collective responsibility of the group. Ergo, David's sins are suffered by all his people. The second way was to emphasize the dualism of God. God was able to render both harm and mercy upon the world. There was no consideration of evil spirits; God had responsbility for a person's fortune or not. Doctors were mentioned rarely in the Old Testament, as were incidences of spiritual healing.

Greco-Roman philosophy also considered illnesses and healings as acts of the Gods; not precipated by sin, but more the dictates of fate. While Plato, in his Dialogues, considered curing the soma as important to cure as the mind, empnasizing treatment of the whole person, he was alone in that view. The reigning Greek thought considered the mind as being trapped in the body; thus,

the body was not considered as important as the mind, the beginnings of dualistic thought in western culture. It was not until the coming of Jesus that Plato's ideas found a forum.

Spiritual Healing in the New Testament With Jesus, came a different interpretation of sickness and healing: Sickness was not to be considered as an act of God. Rather, it was seen as an obstacle in the pursuit of God, at times due to evil spirits, at times coming from undisclosed sources. Whatever the source, Jesus healed people indiscriminately, without prerequisite demands for behaviour change. Not only did Jesus heal but he gave direct orders to his disciples to heal. New Testament healing was done without prerequisites. Any one who desired, received. This emphasized the perspective that God was concerned about all facets of the individual: the body, mind, and soul.

The three Gospels yield forty-one separate healing incidences (seventy-two citations in all) many involving a large number of people (multitudes). Kelsey makes a point that Jesus' healings were not limited to psychosomatic illnesses, but also were experienced by people with purely functional ailments and mental illness. Kelsey chronicles healings for epilepsy, demonic possession, leprosy, lameness, palsy or paralyses, physical deterioration, hemorrhages, fever sickness, blindness, deafness, edema, and raising the dead. Just as Jesus did not heal just one type of illness nor did his disciples. The book of the Acts of the Apostles offers the same types of healings that Jesus rendered.

The Bible records Jesus healing many different illnesses in different ways. Weatherhead (1951) in a detailed analysis of psychology, religion, and the healing process, explored Christianity's healing rituals. The healing miracles of Jesus are classified in three categories towards this end:

1) Those cures which involve the power of suggestion, for example: the cleansing of the leper found in Mark 1: 40-45; Matthew 8: 1-4; Luke 5: 12-14.

2) Those cures which involve complicated and multiple techniques (such as the use of spittle, laying on of hands, suggestion, specific instructions), for example: the Gerasene demonic found in Mark 5: 1-20; Matthew 8: 28-34; Luke 8: 26-39.

3) Those cures which are conducted through the faith of other people or within the psychic atmosphere, for example: Jairus' daughter found in Matthew 9: 18-26; Mark 5: 21-43; Luke 8: 40-56.

Dispensationalism The ability for people to intervene spiritually in Jesus' name for healing purposes was a reality in the early church. However, with the philosophies of Aristotle, St. Augustine, and St Aquinas, the ability for spirits to intervene in the affairs of man came to be considered as impossible. The separation and compartmentalization of the mind, body, and soul became realized and accepted as doctrine for the medieval church. To this end, the church moved from the belief of saving the body in order to save the soul, to just saving the soul. For example, the unction that was once used in healing ceremonies became extreme unction, to be used primarily for anointing those on their deathbeds, and then only after a confession of sins was extracted.

The church did not reject the healing miracles that were recorded during Jesus' time by Him and His Apostles (though some philosophers and theologians did and do). The church instead professed the doctrine of dispensationalism. This doctrine relegates miracles to Jesus' time, positing that the miracles were necessary then to convince people of Jesus' legitimacy as the Christ. As there was now sufficient proof, there was no need for miracles; therefore,

miracles do not exist in present times. The Church Fathers and the leaders of the Reformation, Augustine, Luther, Calvin, believed that if people perceived that miracles could occur in present times (relatively speaking) that people's faith would be contingent on a show of them. To be rid of that "burden", dispensationalism was conceived.

Along with these changes in dogma, the position that disease and illness was a form of punishment by God was resurrected. As mentioned, unction became associated more with the forgiving of sins before death than with its initial function, bodily healing. So much did the church embrace the idea of the relation between sickness and sin, that the Fourth Lateran Council in 1215 forbade doctors from seeing patients without consulting priests, explicitly stating that to save the soul was of more importance than saving the body. The Catholic Church, in 1566, made physicians, who were trying to obtain a license to practice, swear that they would stop seeing patients after three visits if they (the patients) had not confessed their sins (Kelsey, 1973).

Despite the official pronouncements from the church, spiritual healings continued. Oursler (1957), Kelsey (1973), and others, chronicle healing after healing whose source was said to be God, from Jesus' time until the present. These healings were/are fashioned in the spirit of Jesus and the Apostles. The majority of spiritual healings, without serious study, have been dismissed as quackery, as society has had no philosophical basis with which to accept the plausability of these acts. As mentioned, with the works of Freud, Jung, Einstein, and others, a framework is developing for a serious scientific debate regarding healings occuring by virtue of spiritual intervention. A discussion of spiritual healing, how it occurs, and what a spiritual healer is, is appropriate.

The Nature and Functioning of Spiritual Healing Oursler (1957) states that there are two opinions regarding the nature and function of spiritual healing. One opinion suggests that spiritual healing is "healing (solely) within a religious context" without the participation of any other disciplines. The other opinion suggests that spiritual healing is best understood as a cooperating component with the efforts of the medical and psychological disciplines.

Kelsey (1973) and Blades (1979) among others, argue that spiritual healings are a valid entity apart from other disciplines. Kelsey suggests that there are four types of healing: medical, psychological, psychic, and religious or sacramental healing. Blade suggests that spiritual healing be considered "healings of the spirit by the spirit." Both suggest that healing is done not through innate powers of the healer, but by the healer being a conduit for spiritual power to be passed on to the patient. (This emphasizes the need to consider humans as open systems capable of accepting energy from other sources.) While both men point out that there is no hostility or belittlement directed towards the traditional medical disciplines, they emphasize that there are spiritual powers that are capable of healing distinct from medical efforts.

Persons at the Theophysical Research Centre (1975) in a book called "The Mystery of Healing," affirm the view of spiritual healing working in conjunction with other disciplines. They perceive that healing is a "spiritual process proceeding from within outward." They consider the role of therapy to be passive, helping the body readjust itself, and they view illness as a lack of harmony in the body. The role of the spiritual healer, in conjunction with healers from other disciplines, is to promote a reestablishment of that harmony. Oursler (1977) chronicles many healers who feel similarly.

The methods of spiritual healing are usually agreed upon regardless of the theologian's philosophy regarding healing. Also accepted is the notion of healing being good for its own sake and not dependent upon confession (although in some cases, confessing may be what the person needs to help spur the healing process). Commonly mentioned healing methods are: laying on of hands, autosuggestion, mental or absent healing, visiting a healing center (such as Lourdes), prayer, use of sacraments, and faith (Oursler, 1957; Murphy, 1958; Theophysical, 1977; Blades, 1979). These methods clearly have their roots in the practices of Jesus and the Apostles. The question for some is perhaps not regarding what spiritual method is used but whether or not it is used with medical and psychological techniques.

Most theologians also accept and embrace the concept of psychosomatic disease, with some believing that all diseases are psychosomatic (Theophysical, 1977). In accepting this, the concern is with broadening the psyche-soma concept to include the spiritual dimension. As Oursler (1957) notes, when medicine fails people, they turn to healing through faith.

Spiritual Healing and the Chaplain Ministry in Army Medical Centers

Regardless of the civilian liturgical debate regarding the usage of spiritual healing techniques with or without the accompanying medical therapy, it is innappropriate to consider the occurence of spiritual healing without accompanying medical therapy in Army Medical Centers. Advocating the combination of medical therapy, stress-management techniques, and spiritual healing, however, is the focal position for chaplains to take. The combination of spiritual healing and medical therapy is well accepted in the Scriptures (c.f., Kelsey, 1973; p 114, 125).

It is dependent upon the patient's religous background as to the degree the chaplain should verbalize about the spiritual healing conducted. As one chaplain who practices spiritual healing and is also heavily involved in using stress-management techniques puts it: "There is no need to make an announcement to the patient when I am laying on of hands, I just do it." To the degree that the patient is receptive to this type of treatment the chaplain should be verbal about it as it becomes necessary. If the patient is not comfortable with this level of intervention, then there is no reason why the spiritual healing techniques (e.g., absent healing) cannot be used without the patient's compliance for the patient's benefit.

Life After Death The issue of life after death also must be addressed. The Bible records three incidences of Jesus healing and raising people from the dead; Jesus is also recorded as having risen from the dead, proclaiming an after-life. Recent anecdotal works by Moody (1975; 1977) with patients who, after being declared clinically dead, have been revived, suggest that there is a phenomenon to be considered. The revived persons tended to report common experiences that suppose a life after death. Moody reports biblical support for these patients' recollections and increasing church support for the continuation of such works. Ring (1980) has reported the first scientific research on this life after death phenomona confirming much of the anecdotal work of Moody.

Summary of Discussion Group Sessons on Theological Issues Some of the above issues would be addressed during the proposed discussion groups. It is clear, as Kelsey says, that a person's philosophy of God's relations to humans, will determine the level of healing that is embraced. Thus, the issues of mind, body, and spirit relations, spiritual healings, methods of healing, psychogenic disorder and spirituality, and of death and the spirit

must be discussed so as to allow for the chaplain-trainees to accept the broadest base of healing available to them.

Summary of Phase I Training

LJA recommends that the chaplain-trainees participate in a four month course with three components: didactics, experiential training, and theological discussion group sessions. These components are to be directed by a four-member teaching team proficient in: the physiology of stress, the socio-psychology of stress, the training of stress-management modalities, and the theological issues regarding healing. These components are to take place on the grounds of a medical center, which will provide for real life examples for classroom problems. To help orient chaplain-trainees to the physiological and psycho-social responses of the body to stress, LJA recommends that a program learning text be developed. The goal of the activities that occur in Phase I is to prepare the chaplain-trainees for their ministry during Phase II training.

Phase II

Phase II is projected to last eight months. During this phase and with the same team from Phase I, the chaplain-trainees would be exposed to: 1) clinical ministration in the medical center, 2) supervision, both individual and in group discussion sessions, and 3) additional training where warranted. With the foundation that was provided during Phase I, the chaplain-trainees would minister to the needs of psychogenic patients and, if need be, their families and friends. The following discussion is organized by the three components delineated above.

Clinical Ministration

The chaplain-trainees would each be assigned to wards in the medical center to be served on three equivalent rotations. These rotation would include work with cancer patients, with other adults patients and with the in-patient/ambulatory facilities. From exposure to these populations, the chaplain-trainees would be required to use all the skills and knowledge that was taught during Phase I.

Working specifically with cancer patients would help the chaplain-trainees understand the dynamic relations between mind, body, spirit, and physical/social environment, and the empathy that must be shown to all patients with psychogenic diseases. The stress-management techniques learned would have to be applied with discretion and respect for the patient and family. The theological issues regarding life and death that the chaplain-trainees must grapple with would force the chaplain to accommodate and assimilate the information provided in Phase I. In short, all the information, training, and concern of Phase I would be explored with the *chaplain-trainees' ministry to cancer patients.*

The ministry to adults suffering of one or another psychogenic disease would be less dramatic, perhaps than the ministry to cancer patients, but just as important. It is here that the chaplain-trainees would be exposed to a multitude of people with different illnesses. The chaplains would learn to practice discernment and discretion in their ministry to the total needs of the individual.

The in-patient/ambulatory rotation would expose chaplains to situations that would test their individual initiatives. For it would be the chaplain's responsibility to make him or herself appropriately available to a person suffering with a psychogenic disease that may not require long-term hospitalization or is just in need of emergency care. In this less structured environment, the trainees would have to assert themselves in the performance of their duties.

For all the rotations, the healing team concept would be emphasized. This orientation should be familiar to all the chaplains as it compliments the training they received in CPE.

Supervision

Individual In individual supervision, the chaplain-trainee would meet the supervisory chaplain each week to discuss the events of that week. To facilitate those sessions, the chaplain-trainees would keep a daily record of their actions and reflections on these actions. This record would help guide the chaplain-trainees' growth and development throughout the eight month period.

Group Discussion Sessions Once a week, the chaplain-trainees and the teaching team would come together to discuss issues and problems that may have

come up during the week. These groups would be run more as brainstorming rather than as counseling/encounter sessions. The purpose of the group would be to solve problems, not provoke confrontation. The problems that the chaplain-trainees have should be brought out and discussed, with an aim towards discovering alternative methods for solving the problems. This would help the chaplains understand the vast potential for variation in styles and approaches which can have equitable results when ministering to patients with psychogenic diseases.

Training

The training that occurs during Phase I would not afford the chaplain-trainees the opportunity to have substantive practice or interaction with many patients. The training would be confined to learning the techniques. It is during Phase II that the chaplain-trainees would have the opportunity to share these techniques with patients. Assuredly, there would have to be additional training (and perhaps supervision when working with the more sophisticated biofeedback techniques and machines) to help the chaplain-trainees be able to develop a sense of the nuances of all the stress-management techniques and their applicability.

Summary of Phase II Training

LJA recommends that the chaplain-trainees participate in an eight-month residency followup to the Phase I experience. Phase II would have three components: clinical ministrations, supervision, and training. The components would be directed by the same four member team that directed the Phase I training experience.

Summary of Training Program

This report has presented suggestions for the criteria and structure for a year long training program entitled "Psychogenic Diseases: Their Etiology and Psycho-Spiritual Management." The purpose of this training program would be to help accentuate the chaplains ministry within the healing team framework to patients with psychogenic diseases. The report has defined psychogenic disease and discussed its role within the Army; reported on exemplary clinical and Pastoral Education programs for Army chaplains; suggested a role for chaplains on healing teams; and outlined a training course for chaplains on psychogenic diseases and their psycho-spiritual management.

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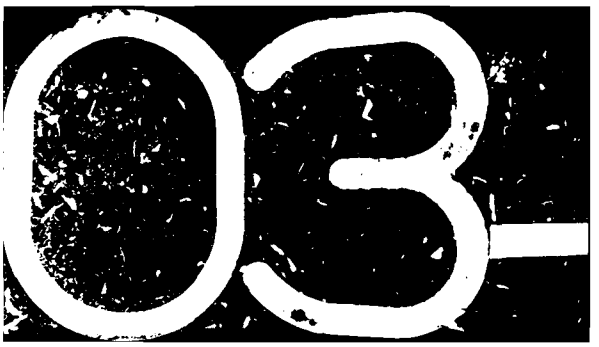
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