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A MIND-BODY APPROACH TO PROMOTE HEALTH AND ENHANCE HEALING

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Interdisciplinary Studies:
Health Arts and Sciences

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by
Lisa Dionne Meyering
September 2013

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ABSTRACT

This project consisted of developing a booklet for consumer use, incorporating a mind-body approach to complement the traditional Western biomedical model. The booklet is intended to reach the broadest possible audience; as such, it is written at a ninth grade level and will be available in physicians' offices as well as to the general public. The general concept is to emphasize non-medical considerations that may be employed to enhance or accelerate the process of healing from illness.

The content of the booklet was limited to research-based data and interventions that are highly ubiquitous and actionable, and with broad applicability. To guide this endeavor, a study of the research and contributions of others was performed. The study focused on three areas: the prevalence and impact of mind-body maladies, the challenge of addressing psychological factors in Western health care, and approaches to mind-body education and care.

The distillation and presentation of this material into a patient-friendly booklet was a creative endeavor, guided by the findings of the study. Taking a "form follows function" approach was determined to be the most practical – i.e., creating the content first, then tailoring size, shape, and appearance for purposes of professional presentation. Per consultation with the graduate advisory committee, the project presented herein is not the published version, but is presented for academic content.

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CHAPTER ONE

INTRODUCTION

It is being increasingly recognized that the outcomes of conventional (Western) medical care could be greatly enhanced by better addressing the role of psychological factors in the creation of sickness or health (Kathol & Gatteau, 2007; Davies & Palsson, 2003; Davies & deGruy, 2003; Sobel, 2000). Reduced medical needs, in turn, can result in reduced medical costs (Kathol & Gatteau, 2007; Sobel, 2000; Friedman, Sobel, Meyers, Caudill, & Benson, 1995; Fries, Koop, Beadle, Cooper, England, Greaves, Sokolov, & Wright, 1993).

An estimated 75 to 80 percent of patients visiting primary care doctors for physical issues present evidence of co-existing psychological factors (Moss, 2003a). At present, however, the place of psychological factors in Western medical care is ambiguous (Lorig, 2010, as cited in Gilkey & Garcia, 2010; Davies & Palsson, 2003). Though educated in principles of psychotherapy and psychophysiology, when it comes to daily practice, the physician's focus is primarily biomedical (Davies & Passon, 2003). With the exception of patients with primary psychiatric disorders, a referral for psychological care is typically given only when allopathic approaches to healing have failed (Moss, 2003a).

Simultaneously, many patients who may stand to benefit from psychological support are dismissive of the idea of seeking such care (Larson, Corrigan, 2010; Corrigan, 2004). This is sometimes attributable to concerns of social stigma, given that insurance disbursements may be subject to review by one's employer or alternatively, a hefty out-of-pocket expense (Corrigan, 2004). Very commonly, it comes back to difficulties with self-stigma (internalization of negative stereotypes) (Larson & Corrigan, 2010), and reticence to accept the fact that psychological factors may be significantly involved (Bakal, Coll, & Schaefer, 2008).

The quandary this situation presents is an "Achilles' heel" in the Western healing system and in the ways mainstream psychotherapeutic healing is packaged and perceived today. This dimension of health and healing is the focus of the burgeoning field of study known as mind-body medicine.

Mind-body medicine is the study of how psychological factors interact with the body to affect health, and of how mind-body interventions may be used to induce or enhance healing (Rotan & Ospina-Kammerer, 2007). Some examples of mind-body interventions include guided imagery, meditation, progressive relaxation, stress management, psychotherapy, hypnosis, music and arts, biofeedback, yoga, support groups, humor and laughter, expressive writing, and prayer (National Institutes of Health's National Center for Complementary and Alternative Medicine [NCCAM], 2008; Rotan & Ospina-Kammerer, 2007). A modest offering of some of these interventions, often in a group format, are now appearing in some Western health care and treatment settings. In such settings, individuals providing mind-body guidance or support typically have credentials in a psychology- or mental health-related field (Cancer Treatment Centers of

America, 2011), nursing (Lyon & Taylor, 2003), or increasingly, the relatively nascent specialty of mind-body medicine (Saybrook University, 2011).

Outside of these select settings, however, a much broader offering of mind-and-body interventions is attracting significant patronage, and the credentials of the individuals providing these can vary widely (NCCAM, 2011). Dominant among these are religious/spiritual offerings (Emery & Pargament, 2004; Larsen & Larsen, 2003 as cited by Gockel, 2009), self-help offerings (Paul, 2001), and complimentary and alternative medicine (CAM) practices (of which mind-body awareness or intervention is a part) (NCCAM, 2011). According to a national study titled "Why Patients Use Alternative Medicine," the key factor identified was the desire for options "more congruent with their own values, beliefs, and philosophical orientations toward health and life" (Astin, 1998, p. 1548). Four "pragmatic" factors, according to Starker (1989), that explain the widespread popularity of self-help books (and reasons associated, more or less, with each of these offerings) include:

(1) Cost – much less than a psychologist;

(2) Accessibility – available when needed;

(3) Privacy – to avoid "going public;" and

(4) Excitement – of associating with a social "in-group" (1989, pp. 5-6).

Non-traditional interventions are being used to fill psychological and pragmatic needs that are typically under-addressed as a part of the healing process in conventional (Western) medical care. Without guidance, patients in need of psychological tools, or interventions, that might be conducive to healing are left to fend for themselves.

Statement of the Problem

Though sufficient research exists, mind-body interventions that may be helpful to healing are underutilized in conventional (Western) medical care (Sobel, 2000; Friedman, Sobel, Meyers, Caudill & Benson, 1995). Primary care staff members have limited time and resources to address psychological factors (Davies & deGruy, 2003; Lorig, 2010, as cited in Gilkey & Garcia, 2010). Patients often resist moving outside the primary care setting for conventional psychological care (Olfson, 1991). Failure to address the role of psychological factors in healing is (1) reducing the efficacy of clinical and biomedical care, (2) contributing to chronic and escalating illness, and (3) resulting in higher health care costs (Kathol & Gatteau, 2007). There is a fundamental need to provide better guidance and support for patients in regard to psychological considerations that may be helpful to healing.

Purpose of the Project

The purpose of this project was to create for the public a research-based user-friendly booklet that provides guidance with regard to psychological considerations that may be employed to enhance, or accelerate, the process of healing from illness.

Need for the Project

Friedman, Sobel, Meyers, Caudill, and Benson (1995) summarize the challenges that presently exist in health care, and the need for pragmatic mind-body approaches, like this patient-friendly booklet, at this time. They write:

> The health care system is reeling under the impact of escalating costs, limited access, and the prospect of an aging population with multiple chronic illnesses that will increase demand for health care... the current health care debate challenges health care providers to look beyond diagnostic categories and disciplinary boundaries, beyond the dysfunctional distinction between mind and body, beyond traditional psychotherapeutic interventions. The challenge is to most effectively [sic] address the true needs that people bring into the health care system and to do so with maximum efficiency (p. 509).

Studies further reveal substantial public "needs," or demands, for offerings that: (1) better integrate with their beliefs and values, (2) are low in cost, (3) are highly accessible, (4) offer privacy, and (5) enhance self-esteem (Astin, 1998, p. 1548; Starker, 1989, pp. 5-6). An easy-to-read booklet that offers psychological considerations for healing is uniquely well suited to address these needs. It is personal, inexpensive, portable, private, and self-empowering. It can also aid healthcare providers in approaching the role of psychological factors in an efficient, non-threatening way, and be helpful in cultivating increased receptivity toward psychological care.

An ad hoc online review of some local (Southern California) hospitals and clinics revealed the following mix of mind-body public offerings:

(1) Support groups are offered for some of the more common medical and mental health challenges of today (e.g., cancer, heart disease, chronic fatigue syndrome, fibromyalgia, bipolar disorder, depression, alcoholism, bereavement, and more). Some of these groups meet in person; others are internet based.

(2) Mind-body group classes, e.g., stress management, yoga, and meditation.

(3) Health ministry programs that include health education, screenings, health counseling, and other offerings can be brought into local religious venues.

(4) Hospital chapels and pastoral care are typically available 24 hours daily for meditation and prayer. Chaplain services are available for comfort and support, pre-operatively, to discuss ethical concerns and end-of-life decisions, and postmortem.

(5) An extensive searchable online "Health Library" is offered by the Loma Linda University Medical Center (a Seventh-Day Adventist institution). It consists of short articles, news items, podcasts, and other digital media, and includes mind-body elements (e.g., "Anger Can Raise Cholesterol," "Tips to Manage Stress," "The Benefits of Laughter") (http://healthlibrary.lomalindahealth.org, 2012).

(6) Two online, printer-friendly, "health guides" – one for adults, one for the care of infants and children – offer preventative care advice and a place for tracking screenings, immunizations, safety data, and personal care (e.g., hygiene, nutrition, weight, etc.). In the 25-page guide for adults, there was a page devoted to the warning signs of depression, with the suggestion of consulting a doctor or qualified health care professional for help if needed.

Additional mind-body offerings may likely be found through involvement with specific support groups – that is, for those who find a support group that matches specific needs, and feel inclined to become involved. Unfortunately, many will not do so.

To the extent this informal sampling is indicative of offerings in other regions, a patient-friendly booklet that offers psychological considerations for healing can provide a unique, efficient method of better addressing some of the "true needs that people bring into the healthcare system" (Friedman, Sobel, Meyers, Caudill & Benson, 1995, p. 509). In their book titled "Healing Body AND Mind: A Critical Issue for Health Care Reform" (part of the *Praeger Series in Health Psychology*), Kathol and Gatteau write, "The evidence mounts daily that the disconnect between body and mind in treating illness peppers the population with poor clinical outcomes and excessive health care costs" (2007, p. 37). As such, there appears to be no better time to produce and provide this offering than the present.

Limitations

This project was subject to the following limitations:

1. Content was limited to research-based data or interventions with reasonably broad applicability (as apposed to being condition-specific). However, additional information, resources, or exceptions that may apply to specific conditions were provided where appropriate.
2. Patient education materials were written at about a ninth grade reading level.

Definitions

Complimentary and Alternative Medicine (CAM):

> As defined by the National Center for Complementary and Alternative Medicine (NCCAM), CAM is "a group of diverse medical and health care interventions, practices, products, or disciplines that are not generally considered part of conventional medicine (NCCAM, 2011, "Defining CAM" section, ¶ 1).

Mind-Body Medicine:

> The definition provided in the text *MindBody Medicine* will be used:
>
> MindBody Medicine is the study of how mental activities influence health and how using mental interventions can change the content of these mental activities by either

> reducing stress or affecting cognitions or emotions in order to improve health. We define mental activities as the processes initiated by the mind (e.g., perceiving, imagining, and remembering) (Rotan & Ospina-Kammerer, 2007, p. 2)

While various definitions exist in the literature, for the purposes of this paper, the definitions of the following terms as provided by the New Oxford American Dictionary (2010) are perfectly suitable. These are as follows:

Heal: Cause to become sound or healthy again.

Illness: A disease or period of sickness affecting the body or mind.

Psychosocial:

Of or relating to the interrelation of social factors and individual thought and behavior.

Stress (psychological):

A state of mental or emotional strain or tension resulting from adverse or very demanding circumstances.

A broader definition (below) from Levi (1972) is also helpful.

Stress (broadly defined):

Any physiologic, psychologic, or behavioral response within the organism elicited by evocative agents (Levi, 1972, as cited in Freeman, 2009, p. 92).

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

Though mind-body approaches to healing have existed throughout the ages, the term "mind-body medicine" is a fairly recent addition to the Western vernacular (Harrington, 2008). The need to address more effectively the role of psychological factors in health and healing is being increasingly recognized (Kathol & Gatteau, 2007). How best to offer mind-body guidance for the public alongside conventional (Western) health care presents a unique challenge.

In 1993, more than twenty-four million Americans viewed Bill Moyer's five-part series *Healing and the Mind,* aired by the Public Broadcasting Service (PBS); the companion book to the series (Moyers,1993) was a bestseller for twenty-three weeks (Harrington, 2008). Soon after, a related guide titled *Mind Body Medicine: How to Use Your Mind for Better Health* was published by Consumer Reports (Goleman & Gurin,1993). This guide, in addition to the attention generated by Moyer's series, is credited with helping to make "mind-body medicine" the "new preferred term of choice" for psychophysiological healing practices (Harrington, 2008, p. 245).

It was also during this timeframe that "mind-body medicine" emerged as a category of *Complementary and Alternative Medicine* (CAM) in a federally commissioned report on the status of such practices (Moss, 1995). However, no single individual, culture, era, or academic discipline can rightfully claim exclusive ownership rights to its birth, study, or practice. In fact, to the majority of the world's population whose primary form of medical care is non-Western, mind-body approaches to healing are not considered "complimentary and alternative" at all, but a part of their healing tradition (Mahler, 1977).

Mind-body historian Anne Harrington writes, "In mind-body medicine we are confronted not with an integrated vision or program but with a patchwork of approaches and understandings that pull in many different directions." (2008, p. 19). Harrington's research led her to identify six distinct "narrative templates" that describe historical and cultural lines of thought upon which the "patchwork" of mind-body interventions is based (p. 25). These are:

(1) "The Power of Suggestion"

This narrative focuses on how psychological influences can produce illusory experiences (e.g., the placebo effect, hypnosis, the influence of authority figures).

(2) "The Body That Speaks"

In this narrative, the individual is made ill by the mind's secrets; symptoms are "coded messages" (p. 27) (e.g., psychosomatic medicine, Freudian or psychoanalytic-type therapies, etiologies related to personality, emotion, or character).

(3) "The Power of Positive Thinking"

In this narrative, illness is produced by "false" beliefs; change the mind, correct the beliefs, and the body will heal on its own (e.g., faith cures, placebo healings, biofeedback, psychoneuroimmunology, laughter therapy, and various ideologies or practices that promote personal empowerment).

(4). "Broken by Modern Life"

In this narrative, illness is the result of chronic stress, or exhaustion, that comes with living an unnatural or fast-paced life in a modern society. Its emphases are on the laboratory science of how chronic stress accelerates the breakdown of bodily organs, and on the life-extending benefits of managing the influence of such stressors in one's life (e.g., stress management, progressive relaxation types of therapies).

(5). "Healing Ties"

In this narrative, illness results from a lack of community/intimacy/ social support; the best medicine is love (e.g., support groups, religious/spiritual affiliations, doctors who show they care).

(6). "Eastward Journeys"

In this narrative, the modern (Western) way of life is imbalanced and spiritually lacking, creating illness; the East (namely China, India, and Tibet) is viewed as spiritual and medical "exemplar" (p. 29) (e.g., practices for strengthening qi (life force), Qi Gong (the mental manipulation of bioenergy), transcendental meditation (TM)) (Harrington, 2008).

As Harrington's findings suggest, the challenge of providing useful mind-body guidance alongside conventional (Western) health care is multi-faceted. To develop a practical, user-friendly booklet for this purpose, a study of important considerations, based upon the research and contributions of others, was needed. As such, the purpose of this chapter is to provide a review of the literature that guided this endeavor, with a special emphasis on three areas: (1) the prevalence and impact of mind-body maladies, (2) the challenge of addressing psychological factors in Western health care, and (3) approaches to mind-body education and care. The chapter concludes with a summary.

The Prevalence and Impact of Mind-body Maladies

All sentient human beings are susceptible to psychological factors that can negatively influence health. Mental and physical health are "indivisible" (Davies & deGruy, 2003, p. xv). Physician-researchers Davies and deGruy (2003) have described this confluence, as seen in primary care patients, as follows:

> One can hardly find in a primary care patient evidence of psychological distress or mental symptomatology without accompanying physical symptomatology (Bridges & Goldberg, 1985; Kroenke et al., 1994). Conversely, physical -- so-called medical -- problems are always accompanied by psychological symptoms (p. xv).

Various studies have revealed that 50-80 percent of patients seen in primary care present symptoms for which no clear-cut organic cause is discovered (Kroenke & Mangelsdorff, 1989; deGruy, 1996; Moss, 2003a).

Psychological factors have been observed to interact with symptoms of illness in a variety of ways. Observations offered from a "clinical" (primary care) perspective, versus an "epidemiological" (correlational) perspective, provide different views and classifications. These are further described below.

Clinical Observations

According to Moss (2003a) (with relevant supplemental research also provided), the more typical (and challenging) patients in primary care present with symptoms that fall into the following overlapping categories:

(1) Somatization disorder

Wickramasekera (2003) defines this disorder as "the process by which an individual, 'hiding' from threatening psychological information, expresses (or in more technical terms, transduces) his or her emotional distress into physical symptoms or maladaptive behavior" (p. 19). Symptoms cannot be explained organically (Moss, 2003a). A partial list of frequently somatized symptoms include: chronic fatigue, chronic allergic reactions, chronic pain, muscular and vascular headache, irritable bowel syndrome, temporomandibular joint pain, primary insomnia, low-back pain, and primary hypertension (Wickramasekera, 2003, p. 19). Though difficult to identify, it is estimated that 50 percent of all primary care patients present somatized symptoms (Brown, Robertson, Kosa, & Alpert,1971; Roberts, 1994, as cited by Wickramasekera, 2003; deGruy, 1996).

(2) "Undifferentiated complaints"

Coined by Hungarian analyst/physician Michael Balint (1964), "undifferentiated complaints" are described as those that fall in the "twilight zone between body and mind" (Moss, 2003a, p. 5). Symptoms are vague and have not yet manifested as a distinct Illness (Moss, 2003a). Examples of such complaints include chest pain, fatigue, dizziness, headache, edema, back pain, dyspnea, insomnia, abdominal pain, numbness, impotence, weight loss, cough, and constipation (Blout, 1998, p. 6, as cited in Moss, 2003a, p. 5). Such complaints reportedly comprise 40 percent of visits to primary care providers. Blout reports that a year later, only 10-15 percent of these complaints were found to result in a diagnosis (1996, pp. 6-7, as cited in Moss, 2003a, p. 5).

(3) Psychophysiological disorders related to psychosocial stress

Patients with measurable physiological symptoms that tend to worsen with situational or cognitive stress comprise this category (Gatchel & Banchard, 1993, as cited in Moss, 2003a). An online review of the first 100 research articles found via the EBSCOhost system (academic search engine), using the search term "psychophysiological disorders," revealed studies focused on the following conditions: insomnia, sleep walking and night terrors, seasonal affective disorder (SAD), attention deficit/hyperactivity disorder (ADHD), autism spectrum disorders, various gastrointestinal disorders, various eating disorders, various psychiatric disorders, tic disorders, speech disorders, temporomandibular disorders, multiple sclerosis, fibromyalgia, Huntington's disease, and tinnitus (2012). Moss estimates that 75-80 percent of primary care patients present symptoms that are psychophysiological or related to psychosocial stress in some way (2003a, p. 6).

(4) Posttraumatic conditions

Patients who have experienced serious trauma are more vulnerable to emotional and physiological arousal and to the somatization of symptoms (Andreski, Chilcoat, & Breslau, 1998, as cited in Moss, 2003a). This is especially true of patients who experienced childhood trauma, which can linger within for many years (Moss, 2003a). The relationship of trauma to delayed symptoms of illness often goes unrecognized by either the physician or the patient (Moss, 2003a). Though difficult to quantify, posttraumatic symptoms of illness are experienced by "many" (Moss, 2003a, p. 6).

(5) Somatic symptoms of psychiatric disorders

Individuals with psychiatric disorders – particularly anxiety and/or mood disorders – are more susceptible to somatic symptoms such as insomnia, acute chest pain, respiratory problems, loss of energy, loss of appetite, concentration problems, and suicidal behaviors (American Psychiatric Association (APA), 2000; Baehr & Rosenfeld, 2003; Moss, 2003a). Such disorders are common, presently affecting about 15 to 20 percent of the population in the span of a lifetime (Ragier, Narrow, & Rae, 1990; Baehr & Rosenfeld, 2003). Higher-risk groups for anxiety disorders include women aged 25 to 44, individuals who are separated/divorced, and individuals with low socioeconomic status (Ragier et al.,1990). Epidemiologists predict that depression will soon become the first- or second-largest health burden and cause of disability worldwide (The Harvard School of Public Health on Behalf of The World Health Organization and The World Bank, 1999; The World Health Organization, 2012). Anxiety and mood disorders may be caused by genetic, biological, and/or psychosocial factors (Baehr & Rosenfeld, 2003; Moss, 2003a, Moss, 2003b).

(6) Symptoms of chronic disease

This final category of patients identified by Moss describes the predominant health predicament of individuals worldwide (Institute for Health and Aging, 1996) including more than 45 percent (90 million) Americans (Hoffman, Rice, & Sung, 1996). "Chronic" disease, as

> apposed to "acute" (short-term, intensely symptomatic) disease, usually begins gradually, has many causes, tends to be difficult to diagnose (especially early), and can last indefinitely (Lorig et al., 2000). Examples of common chronic conditions include arthritis, asthma and lung disease, cancer, chronic heartburn and acid reflux, chronic pain, congestive heart failure, diabetes, heart disease, hepatitis, high blood pressure, HIV disease (AIDS), hypertension, irritable bowel syndrome, kidney stones, multiple sclerosis, chronic mental illness, Parkinson's disease, peptic ulcer disease, renal failure, and stroke (Lorig et al., 2000; APA, 2000). The role of lifestyle, personal choices, emotions, and stressors are vital considerations in the etiology and management of these conditions (Lorig et al., 2000; Moss, 2003a). Patients with chronic illness are also the most expensive to care for, accounting for up to three quarters of all health care costs (Hoffman et al.,1996; Moss, 2003a).

Ultimately, writes Moss, "the mismatch between the health needs of the typical patient and the standard medical responses produces a waste of medical resources, frustration for patient and physician, and the danger that acute conditions become chronic" (2003a, p. 4). Consequently, in addition to being mindful of these patient categories, addressing the frustration experienced by patients and their physicians was another important consideration for this project.

For both patients and physicians, recurring "medically unexplained symptoms" (MUS), can be highly frustrating (Moss, 2003a; Nettleton, Watt, O'Malley & Duffey, 2003). Nettleton et al. (2003) systematically examined the narratives of individuals living with MUS and found their primary concerns to be: (1) that their symptoms might be judged to be "all in the mind," and (2) that there is "no one to turn to for help and support" (p. 206). Moss (2003a) similarly describes his observations in Western health care as follows:

> "Physical medicine specialists throw up their hands and declare, 'This problem belongs in psychiatry.' The patient arrives in the psychiatric specialty clinic hurt, bitter, and discouraged, declaring that 'My doctor thinks my problem isn't real'..." (p. 11).

A 2001 article by Aronowitz offers added insight and seasoned advice about when symptoms become a disease. In his insightful article, Aronowitz chronicled the evolution of symptom-based diagnosis to sign-based (observable, testable) diagnosis, and the increase of "medical orphans" that has resulted (p. 803). He suggested explaining to such patients that this predicament is neither the fault of doctors nor patients, but is largely attributable to "the limitations of medical knowledge and the necessarily imperfect match between individual suffering and medical categories." (2001, p. 805). He summarized by emphasizing the need, in clinical care, to recognize and accommodate the "essential continuity" between those patients whose suffering is unnamed, and those with a clinical diagnosis (2001, p. 808).

Chronic frustration often leads to anger, fear of the future, loss of self-esteem, anxiety, and depression (Lorig et al., 2000). Such effects are common among patients who suffer from chronic illnesses (Lorig et al., 2000). Stress and negative emotions, in turn, can increase perceptions of discomfort or pain (Lorig et al., 2000), and further undermine health and healing (Glaser & Kiecolt-Glaser, 2005; Scheier & Bridges, 1995). Chronic illnesses perceived by patients as serious and uncontrollable sometimes result in escapist-avoidance behaviors that may exacerbate their conditions (Bucks et al., 2011; Lazarus & Folkman, 1984).

A concept put forth by Bandura (1997) that helps to explain feelings of frustration is one's need for "self-efficacy." Bandura defined self-efficacy as "the conviction that one can successfully execute the behavior required to produce the outcomes" (as cited in Champion & Skinner, 2008, p. 49). The concept of self-efficacy has been integrated into several prominent theories related to health behavior change, including the Health Belief Model (HBM), the Integrated Behavior Model (IBM), Social Cognitive Theory (SCT), the Transactional Model of Stress and Coping, and the Stages of Change (Transtheoretical) Model. The practical application of such theories, and other expert recommendations that guided this project, will be discussed later in this chapter, following consideration of mind-body observations made from an epidemiological perspective.

Epidemiological Observations

Observations from an epidemiological perspective focus on psychological factors associated with social relationships, various life events, and signs or symptoms of illness. Correlations, or links, are found among data gathered over time. In the text *Mosby's Complementary and Alternative Medicine, A Research-Based Approach* (Third Edition) Freeman (2009) presents the evolution of this research from its beginnings (in the 1970s) to the present. An overview of some key concepts and relevant supplemental research findings are offered below.

In the interest of public health, early epidemiological studies focused primarily on "social interactions" – the amount of time spent with others, the context (activities, people), and corresponding health outcomes. A desire to expand upon these findings compelled researchers to examine more closely the influence of "social support" – by looking at time spent with others, the quality of these relationships (e.g., fulfilling or disturbing), and corresponding health outcomes (Freeman, 2009). Peer reviews of this epidemiologic literature have led to the same conclusion: social connectedness and personal health are robustly linked (Cobb,1976; House & Landis, 1988). The lower the quantity or quality of relationships, the higher the risk of illness and death (House & Landis, 1988).

Studies of health outcomes associated with intimate (close, familiar) relationships followed. These studies focused predominantly on what came to be known as the "relationship passages," which, as summarized by Freeman (2009), included:

(1) Marital adjustment – the newlywed period, marital adaptation, unhappy marriages

(2) Marital disruption – separation, divorce, widowhood

(3) Marital and family challenges – caregiving

(4) Social isolation or loneliness – school, separation, illness, or social maladjustment (p. 90).

Though each of these passages presents a different set of challenges, all came to be recognized as "chronic stressors," associated with an increased risk of illness and/or death from a variety of causes (Freeman, 2009, p. 90). These findings suggest that the state of intimate relationships should be considered seriously in relation to their impact on health and healing.

Tangent studies of the biological effects of stress offered findings that epidemiologists used to understand this research better, and in time, to map biological effects linked to a variety of chronic (repeating) and acute (short-term) psychological stressors, such as the effects of war, or of college exams (Freeman, 2009). Three indicators of stress found to independently predict morbidity and mortality became very useful to these studies: high levels of serum cholesterol (Friedman, Rosenman, Carroll, & Tat, 1958), high levels of serum uric acid (Kasl, Cobb, & Brooks, 1968; Rahe & Arthur, 1967), and immune suppression (Jermmott et al., 1983) (Freeman, 2009). Finally, specific pathways between the sympathetic nervous system, the endocrine system, and the immune system that are involved in these mind-body effects (and others) were identified (Freeman, 2009).

Some of the more ubiquitous and actionable findings to come out of these studies are summarized below:

- Social interaction is important to health and healing (House & Landis, 1988; House, Robbins, & Messner, 1982). A moderate level of social interaction is most healthful (Kessler & McLeod, 1985). Social isolation greatly increases the risk of illness and death (Berkman & Syme, 1979; House, Robbins, & Metzner, 1982; Schoenbach, Kaplan, Fredman, & Kleinbaum, 1986; Welin et al., 1985; Orth-Gomer & Johnson, 1987). Excessive or negative social interaction may increase levels of anxiety and depression (Kessler & McLeod, 1985). However, what constitutes "excessive" varies by individual temperament (introvert or extrovert) (Kroeger & Thuesen, 1988, as cited in Freeman, 2009), coping style (Kessler & McLeod, 1985), and the stress of other social/family issues (Fischer, 1992, as cited in Freeman, 2009).
- Being an active member of a group, or a church, is linked to increased longevity and survivorship (Berkman & Syme, 1979; Schoenbach et al., 1986). Outside activities and contacts of various kinds can be beneficial in their own ways (Welin et al., 1985). Just living with

someone has been found to reduce the risk of recurring and fatal cardiac events (Case et al., 1992).

- Supportive relationships are particularly healthful (Cobb, 1976). Social support is robustly associated with better health and a longer life (House, Robbins, & Metzner, 1982; House & Landis, 1988). Cobb (1976) first defined "social support" as "information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations" (p. 300). Another helpful definition was developed for a study by Thomas, Goodwin, and Goodwin (1985); in this study, "social support" was defined as "the presence of satisfying relationships with trusted individuals in whom the participants were able to confide" (Freeman, 2009, p. 95). After reviewing numerous studies, Cobb (1976) found that social support (1) "buffered" the effects of stress for individuals in crisis, (2) reduced the level of medications required, (3) accelerated healing, and (4) increased compliance with prescribed medical treatments (as cited in Freeman, 2009, p. 91).
- Individuals with supportive, intimate relationships (e.g., spouse, family, close friends) receive the greatest health benefits (Berkman & Syme, 1979). On the whole, these individuals (1) report fewer injuries and chronic illnesses (Verbrugge, 1979; Renne, 1971), (2) heal faster (Cobb, 1976), and live longer (Berkman & Syme, 1979). A minimum

of one supportive, meaningful relationship seems to be needed for longevity (Freeman, 2009).

- While the physiological effects of a short-term stressor, like an exam, typically subsides in one to two hours, a stressor that is ongoing, or that frequently repeats, wears on the body and increases the risk of illness (Freeman, 2009). Intrusive thoughts -- such as memories of a traumatic event, or persistent worries about the future -- are also considered chronic stressors (Freeman, 2009; Magee & Teachman, 2012). Suppression of such thoughts and emotions has been found to prolong and increase stressful effects (Wegner, 1994). Researchers attribute psychological stress to the fear of an inability to cope with a given situation (Centre for Stress Management, 2011). Increasing knowledge and skills relevant to the threatening situation helps to increase self-efficacy and reduce fears (Lorig et al., 2000; Freeman, 2009). Interventions that induce relaxation can help to offset the deleterious effects of stress (Kiecolt-Glaser et al., 1986, as cited in Freeman, 2009). Individuals who develop significant illness are likely to have experienced higher than usual levels of chronic stress in the preceding year (Rahe, Meyer, Smith, Kjaer, & Holmes, 1964).
- While relationships are crucial to longevity, relationship-related challenges can be a major cause of chronic stress (Cartensen,

Levenson, & Gottman, 1995; Malarkey, Kiecolt-Glaser, Pearl, & Glaser, 1994; Kiecolt-Glaser et al.,1993, as cited in Freeman, 2009). This is especially true of intimate relationships, as the bonds of intimate relationships can be extremely strong (Bolby 1975, as cited in Freeman, 2009). When the connectedness of an intimate relationship is threatened or lost, the "separation distress" that results becomes a chronic stressor (Brown et al., 1980, as cited in Freeman, 2009, p. 103) – until the conflict is resolved, or until the separation distress diminishes with time, perhaps facilitated by a new relationship (Kitson & Raschke, 1981, as cited in Freeman, 2009). Chronically abrasive and unhappy marriages are linked to poor physical and psychological health, especially for individuals already in a susceptible state (Carstensen, Levenson, & Gottman, 1995; Renne, 1971, as cited in Freeman, 2009). Freeman (2009) further recapitulates the research on "marital disruption" as follows:

> Marital disruption was found to be the single most powerful sociodemographic predictor of stress-related physical illness, with separated individuals reporting 30% more acute illness and physician visits than their married counterparts (Somers, 1979). With age, race, and income variables controlled, separated and divorced people still obtained the highest rates of acute medical problems, chronic medical conditions limiting social activity, and

> disabilities as compared with married people (Verbrugge, 1979). Separated and divorced individuals also had a higher rate of death from infectious diseases, including up to six times the number of deaths from pneumonia (Lynch, 1977) (p. 103).

Such findings, according to Freeman (2009), "...have implications for the need to refocus efforts on the marital state and the quality of relationships when considering such questions as therapeutic interventions, health care costs, and health management" (p. 105).

- Caregiving – of a chronically ill parent, child, sibling, or spouse – is another common source of chronic stress that often continues for many years (Freeman, 2009). Emotions commonly experienced by caregivers include guilt, anger, depression, and fear of the future – in relation to patient care, as well as for personal health (Freeman, 2009). Over time, the emotional "wear and tear" of caregiving has been found to degrade immune function and increase inflammation in the body (Keicolt-Glaser et al., 1991; Freeman, 2009). Viral and upper respiratory infections are seen more frequently in this group (Keicolt-Glaser et al., 1991). Caregivers are also more susceptible to the diseases of aging, such as Alzheimer's disease, cardiovascular disease, arthritis, type 2 diabetes, osteoporosis, certain cancers, physical frailty, functional decline, and periodontal disease (Freeman, 2009). Negative physiological effects sometimes persist for years after an extended period of caregiving has passed, particularly for individuals with low social interaction and support (Esterling, Kiecolt-Glaser, & Glaser, 1996). Multiple reviews of stress-management interventions for caregivers of patients with Alzheimer's disease report that "skills training" – focused on changing patient behaviors, and on acquiring specific skills in patient care – has produced the greatest long-term benefits to caregivers' morale and mental health (Bourgeois, Schulz, & Burgio, 1996; Knight, Lutzky, & Macofsky-Urban, 1993). For depression and relationship challenges, individual counseling was found to be helpful (Bourgeois, Schulz, & Burgio, 1996; Knight, Lutzky, & Macofsky-Urban, 1993). Freeman (2009) warns, however, that most family therapists focus primarily on increasing personal "autonomy" and "individuation," which conflicts with the goals of social support in patient care (p. 103). Caregivers who utilized services regularly to assist with patient care were found to receive moderate stress-reduction benefits as well (Bourgeois, Schulz, & Burgio, 1996; Knight, Lutzky, & Macofsky-Urban, 1993).

- The death of a spouse or a child is widely considered the most painful (and stressful) event a person can experience in life (Freeman, 2009). Epidemiological studies on mind-body effects are limited; some key findings highlighted by Freeman (2009) are as follows: Highly unhealthful immunologic and hormonal effects can result, particularly during the first two months after loss (Bartrop, Lazarus, Luckhurst, Kiloh, & Penny, 1977; Schleifer, Keller, Camerino, Thornton, & Stein, 1983). Continued effects have been found to persist at an "intermediate" level, improving gradually for up to 14 months later (Schleifer et al., 1983). Epidemiologic studies suggest an increased likelihood of death among windows and widowers in bereavement (Helsing & Szklo, 1981; Helsing, Szklo, & Comstock, 1981; Schleifer et al., 1983).

- Social support, emotional expression, positive mood states and imagery, and stress reduction have been observed to have healthful effects at a cellular level, namely by improving immunity and hormonal function, and by reducing inflammation (Kiecolt-Glaser et al., 1986; Kiecolt-Glaser et al., 1985; Freeman, 2009). Mind-body interventions that facilitate these effects are recommended for individuals dealing with chronic psychological stressors, psychosocial or otherwise (Freeman, 2009). Frequent practice has been observed to yield better results (Kiecolt-Glaser et al., 1986).

Freeman (2009) concludes her epidemiologic overview by stating that "when illness strikes – especially chronic illness – the psychologic stressors in the life of the individual and his or her family need to be assessed, and potential interventions and strategies for stress reduction need to be discussed as part of the health care plan" (p. 123). An important objective of this project, therefore, was to produce a product that facilitates the assessment of such stressors, as well as appropriate mind-body interventions, as an integral part of a patient's health care plan.

Other Observations

There is ample research from the field of psychology to suggest that, beyond genetics and personal history, emotions and behaviors are highly situational. This finding is highly relevant as it pertains to the assessment of both public and personal stressors, as well as to the creation of interventions, or new "situations," with psychological benefits to health. For example, studies show that attention to environmental stimuli – e.g., aesthetic appeal, windows/sunlight, orderliness, odor, temperature, and the sounds of a patient's environment – can help to reduce distress, promote a sense well-being, encourage social interaction and interest in activities, improve sleep, and encourage healing (Dijkstra, Pieterse, & Pruyn, 2006; Freeman, 2009; Tanja-Kijkstra, 2011) The identification of situational "triggers" that precede unhealthful mental and physical behaviors is an important consideration; for example, Tanja-Kijkstra (2011) found that minimizing the view of medical equipment (tubes, monitors, etc.) is helpful in mitigating patient stress (Tanja-Kijkstra, 2011). Conversely, triggers may also be used purposefully, as interventions. For example, music can trigger positive memories and moods and help to dispel loneliness and agitation – even among individuals with dementia (Cuddy & Duffin, 2005; Sherratt, Thorton, & Hatton, 2004). Findings such as these demonstrate that even small "situational" changes may be made that can have a positive influence on a patient's health.

Studies of "remarkable survivors" have described introspective journeys leading to increased autonomy (agency) and authenticity (truth) in their lives

(Cunningham, 2003). Personal values and problem areas were clarified, changes were made, and increased freedom, harmony, self-efficacy, and acceptance resulted (Breitling-Winkler, 2008). As such, these individuals often came to view their illnesses as gifts (Taylor, 2000; Brennan, 2001; Maliski, Heilemann, & McCorkle, 2002; Coward, 1997). The overarching goal of this project was to develop a booklet for patients that may help activate and/or support this self-healing process. By facilitating an awareness of the context of an illness, patients (and caretakers) will be better able to help themselves – by addressing internal and external stressors, and by making changes that better support healing in their lives.

The findings presented thus far provided the conceptual framework for content of this project booklet. The following section explores some "situations" that interfere with effectively addressing psychological factors.

The Challenge of Addressing Psychological Factors in Western Health Care

The goal of bridging mind-and-body care presents a unique challenge. Many barriers to addressing psychological factors more effectively have been identified. Some of these are found within the infrastructure and culture of Western health care. Others stem from negative associations, or stereotypes, connected with the label of "mental illness."

Conventionally, the Western physician's primary responsibility and focus is seen to be physiological, and psychological care is a separate matter – the domain of psychologists and other behavioral professionals – practiced in a separate place of business. However, physician referrals to mental health professionals are underutilized. The situation is twofold: Physicians typically offer such referrals only when allopathic approaches to healing have failed (Moss, 2003a), and, when offered, patients frequently (about 30-50% of the time) refuse to go (deGruy, 1996). The wisdom of introducing a mind-and-body approach to healing earlier in patient care is being increasingly recognized (Moss, 2003a). The challenge in Western health care is to find ways to make this happen.

Astin, Soeken, Sierpin, and Clarridge (2006) surveyed physicians nationally to discover their attitudes toward addressing psychosocial factors as a part of diagnosis and treatment, and barriers limiting their interest in the use of evidence-based mind-body interventions. It was found that while 66% percent of the physicians surveyed believed that psychosocial interventions would lead to "moderate" or "big" improvements in treatment outcomes, only 22% percent indicated a "high" or "very high" interest in additional training in these methods. Two significant barriers limiting physicians' interest were "lack of [clinical] time" (70%) and "inadequate reimbursement to address the psychosocial domain" (85%). Other significant barriers identified were "perceptions that training is poor in these areas," "feelings of low self-efficacy to address psychosocial issues," "the perception that such factors are difficult to control," and "lack of knowledge of the evidence-base supporting the role of psychosocial factors." (p. 557). Only

25% of physicians rated their education (medical school and residency) as "helpful" to the diagnosis and treatment of psychosocial factors; 44% rated their education to be "unhelpful." Male physicians were less likely to view psychosocial factors as important to treatment outcomes. The authors of this study concluded that in many ways, the present health care delivery system may be "antithetical to the biopsychosocial model" (p. 557).

To recapitulate in a way that pertains to this project: Evidence-based mind-body interventions that circumvent these obstacles, integrate easily, and are agreeable to patients, are likely to meet with greater acceptance and use in the primary care setting. The use of a patient booklet addresses these first two criteria. However, mental health is a sensitive issue. To develop a booklet that will be agreeable to patients, it is important to understand patients' concerns with regard to seeking "psychological" care.

Research confirms that a major barrier to seeking psychological care is the fear of stigma, stemming from stereotypes connected with the label of "mental illness" (Corrigan, 2004; Larson & Corrigan, 2010). Three stereotypes commonly connected with mental illness are violence, incompetence, and weakness of character (Corrigan, 2004).

Patients' concerns with regard to these stereotypes fall into two categories: public (or social) stigma, and self-stigma. Corrigan (2004) distinguishes public stigma as "what a naïve public does to the stigmatized group when they endorse the prejudice of that group," and self-stigma as "what members of a stigmatized group may do to themselves if they internalize the public stigma" (Corrigan, 2004, 616).

Concerns that patients frequently have about care-seeking and public (or social) stigma include:

(1) The disapproval of family members (Corrigan, 2004);

(2) The possibility of being seen (coming and going) by friends, co-workers, clients or customers (especially in close-knit, rural communities) (Larson & Corrigan, 2010);

(3) The possibility of insurance disbursements for psychological care being reviewed by employers (Corrigan, 2004);

(4) The possibility of confidential information about one's mental health being shared with other parties, and used against him/her (e.g., in divorce/child-custody battles, background/security clearances for potential employers, landlords) (Corrigan, 2004); and

(5) The possibility of receiving less attention/care by physician(s) for medical problems (Corrigan, 2004).

Fundamentally, writes Corrigan (2004), public stigma poses a threat because it "robs people social opportunities" in a variety of ways (p. 614).

Concerns that patients frequently have about care-seeking and self-stigma involve self-esteem and self-efficacy (Corrigan, 2004). Some specifics include:

(1) Seeing one's self as weak and incompetent (Larson & Corrigan, 2010);

(2) Feelings of shame for self, family (Corrigan, 2004); and

(3) Seeing one's self as "less valued in society" (Larson & Corrigan, 2010, p. 525).

If not addressed (or challenged), self-stigma can result in:

(1) "Lower social interaction" and "diminished relationships" (Allport, 1979, as cited in Larson & Corrigan, 2010, p. 525);

(2) "...avoiding...[various] opportunities at which individuals might otherwise succeed" (Link, 1982, 1987, as cited in Larson & Corrigan, 2010, p. 525);

(3) "Lack of drive to pursue life goals" (Larson & Corrigan, 2010);

(4) Feelings of anguish (Ritcher & Phelan, 2004, as cited in Larson & Corrigan, 2010); and

(5) Reduced "quality of life" (Corrigan, 2004, p. 618).

To develop a booklet that will be agreeable to patients, therefore, it is important to diminish the threat of stigma – by enabling the user to be seen in a positive light by others, and by nurturing self-esteem and self-efficacy. Some methods/guidance found in the literature for reducing treatment-related stigma include:

(1) Encouraging endorsement of the treatment by family members (Greenley, Mechanic, & Cleary, 1987);

(2) Empowering patients via participation in self-care (Speer, Jackson, & Peterson, 2001); and

(3) Encouraging belief in treatment success (via evidence/education) (Meltzer, Bebbington, Brugha, Farrell, Jenkins, & Lewis, 2003; Corrigan, 2004).

Being mindful of patients' concerns, and incorporating these methods where feasible, may help to reduce barriers associated with Western "psychological" care.

Approaches to Mind-body Education and Care

Evidence-based strategies for "health behavior change" already exist that are applicable to the delivery of mind-body education and care, as well. Guidance from experts in "health communication," and in matters pertaining to patients' religion/spirituality is also helpful. No single strategy, or theory, is universally appropriate; the insights and guidance offered must be culled and shaped to the task at hand (Rimer & Glanz, 2005). An overview of some strategies that offered practical guidance for this project is presented below.

The Stages of Change (Transtheoretical) Model (TTM)

The focus of this approach is on the stages of health behavior change, and on the kind of information/support that is most beneficial to people at each stage. The idea is to "work in harmony with how people change naturally" (Glanz, Rimer, & Viswanath, 2008, p. 102). The goal is to facilitate progress from one stage to the next stage on the "stages of change" continuum. As presented in *Theory at a Glance: A Guide For Health Promotion Practice* (Second Edition), the five stages of health behavior change, and some suggested strategies for each stage, include:

[1] Precontemplation

Definition: Has no intention of taking action within the next six months

Potential change strategies: Increase awareness of need for change; personalize information about risks and benefits

[2] Contemplation

Definition: Intends to take action in the next six months

Potential change strategies: Motivate; encourage making specific plans

[3] Preparation

Definition: Intends to take action within the next thirty days and has taken some behavioral steps in this direction

Potential change strategies: Assist with developing and implanting concrete action plans; help set gradual goals

[4] Action

Definition: Has changed behavior for less than six months

Potential change strategies: Assist with feedback, problem solving, social support, and reinforcement

[5] Maintenance

Definition: Has changed behavior for more than six months

Potential change strategies: Assist with coping, reminders, finding alternatives, avoiding slips/relapses (as applicable) (Rimer & Glanz, 2005, p. 15)

With respect to this model, this project (booklet) primarily targets individuals in the "Precontemplation," "Contemplation," or "Preparation" stages of change. As such, the information/support offered focuses primarily on increasing awareness, providing encouragement and motivation, and assisting patients toward taking action.

The Health Belief Model (HBM)

The focus of this approach is on what motivates people to take action in order to "prevent, screen for, and control illness" (Rimer & Glanz, 2005, p. 13). The six constructs (motivators/considerations) involved, and some supportive strategies for each, are presented in the text *Health Behavior and Health Education: Theory, Research, and Practice* (Fourth Edition), as follows:

[1] Perceived susceptibility

Definition: Belief about the chances of experiencing a risk or getting a condition or disease

Application: Define population(s) at risk, risk levels; personalize risk based on a person's characteristics or behavior; make perceived susceptibility more consistent with individuals actual risk

[2] Perceived severity

Definition: Belief about how serious a condition and its sequelae are

Application: Specify consequences of risks and conditions

[3] Perceived benefits

Definition: Belief in efficacy of the advised action to reduce risk or seriousness of impact

Application: Define action to take: how, where, when; clarify the positive effects to be expected

[4] Perceived barriers

Definition: Belief about the tangible and psychological costs of the advised action

Application: Identify and reduce perceived barriers through reassurance, correction of misinformation, incentives, assistance

[5] Cues to action

Definition: Strategies to activate "readiness"

Application: Provide how-to information, promote awareness, use appropriate reminder systems

[6] Self-efficacy

Definition: Confidence in one's ability to take action

Application: Provide training and guidance in performing recommended action; use progressive goal setting; give verbal reinforcement; demonstrate desired behaviors; reduce anxiety (Glanz et al., 2008, p. 48).

Strategies of this approach were applied, or "shaped," to fit the current project as follows:

(1) Information was presented in a way that personalizes the impact (susceptibility, severity) of psychological factors on health, and the benefits of taking action.

(2) To help remove barriers and foster self-efficacy, realistic, concrete steps toward desired goals were offered.

Pfizer Principles for Clear Health Communications (Pfizer Inc., 2012)

This online guide offers expert recommendations for health communications for the broad public audience. Guidelines specific to written communications (and highly applicable to this project) are as follows:

(1) Explain the purpose and limit the content
   a. This involves explaining, from patients' viewpoints, why the content is important and what key topics will be covered.
   b. Leaving out unnecessary content helps keep the focus on what patients what to know.

(2) Involve the reader
   a. Written materials should engage the reader by emphasizing desired patient actions and behaviors. Asking the reader to write

down action steps or questions creates interaction with the written materials.

    b. Making the document content and design appropriate to patients' culture, age, and gender also enhances reader engagement.

(3) Make it easy to read

    a. Patient materials should be written in plain language. Writing in short sentences and using common words instead of medical jargon improves readability. Readability calculators are available to estimate the reading grade level of the text. Patient education materials should be written at about a 6th grade level.

    b. Other aspects of the writing style can also make documents easier to read. When writing, we should use a conversational style with an active voice. Breaking up complex topics is helpful. Providing examples for difficult words and concepts makes the information easier to understand.

(4) Make it look easy to read

    a. Well-designed patient education materials use headings to organize information. They also include adequate white space to break up the density of the text.

    b. Choosing the type style is also important. Avoid reverse type, all caps, and italics. Choose colors that provide a sharp contrast, and use large type (14 point), especially when writing for elderly patients.

(5) Select visuals that clarify and motivate

Culturally appropriate visual images can draw patients in. They are also important for explaining concepts, but visuals with excessive detail can be distracting (Pfizer Inc., 2012, "How do the principles of clear health communication apply to written communication?" section, ¶ 2).

Care was taken develop patient communications by these guidelines (as determined to be feasible for this project).

Advice for Addressing Patients' Religion/Spirituality

Individuals dealing with serious illness often find themselves in an existential crisis as well (Post, Puchalski, & Larson, 2000). Inquiring about the role of religion or spirituality in a patient's life can yield important insights for the physician, improve the physician/patient relationship, and encourage a patient's spiritual journey (whatever it may be) toward better psychological health (Post et al., 2000). For those so inclined, becoming a part of a religious or spiritual "family," or group, can increase much-needed social and behavioral support, as well (Post et al., 2000).

To open discussion about the role religion/spirituality in patients' lives (in a way that respects professional and ethical boundaries), some questions developed by Puchalski (1999) (as cited in Post, Puchalski, & Larson, 2000) include:

(1) Do you consider yourself spiritual or religious?

(2) How important are these beliefs to you, and do they influence how you care for yourself?

(3) Do you belong to a spiritual community?

(4) How might healthcare providers best address any needs in this area? (p. 580).

For this project, care was taken approach patient communications about religion/spirituality in a professional, ethical way, as suggested by these guidelines.

Summary

This project was developed for optimum impact for a broad public audience. It was based on a thorough literature review to determine public needs, best practices, and forward thinking regarding both content and presentation.

A review of the prevalence and impact of mind/body maladies revealed several psychological/circumstantial factors that are strongly associated with symptoms with illness:

- Emotional suppression/avoidance (Moss, 2003a)
- Feelings of frustration/low self-efficacy related to medically unexplained symptoms (MUS) and chronic illness (Nettleton, Watt, O'Malley & Duffey, 2003; Lorig et al., 2000)

- Low quantity/quality of relationships (House & Landis, 1988)
- Loss of a loved one (e.g., separation/divorce, death) (Freeman, 2009)
- The emotional "wear and tear" of being a caretaker (when a loved one is ill) (Freeman, 2009)
- Situational factors (e.g., unpleasant/disturbing environmental stimuli; "triggers" that precede unhealthful mental and physical behaviors) (Dijkstra, Pieterse, & Pruyn, 2006; Freeman, 2009; Tanja-Kijkstra, 2011)
- A need for greater autonomy (agency) and authenticity (truth) in one's life (Cunningham, 2003)

These findings provided the conceptual framework for content of the booklet.

A review of challenges involved with addressing psychological factors in Western health care revealed the following:

- Physicians report having insufficient time, training, and financial motivation to address psychological factors (Astin et al., 2006).
- Male physicians were found to be less likely to view psychological factors as important to treatment outcomes (Astin et al., 2006).
- Physician referrals to psychological care are typically offered only after allopathic approaches to healing have failed (Moss, 2003a).
- Patients who are offered referrals for psychological care frequently (about 30-50% of the time) refuse to go (deGruy, 1996).
- Patients' concerns with pursuing psychological care stem from negative associations, or stereotypes, connected with the label of "mental illness,"

and the fear of negative repercussions related to public and/or self-stigma (Corrigan, 2004; Larson & Corrigan, 2010).

An "intervention" offered in the form of a patient booklet circumvents many of the concerns voiced by physicians, and integrates easily into the primary care setting. It can also aid physicians in approaching the role of psychological factors in an efficient, non-threatening way, and be helpful in cultivating increased receptivity toward psychological care. To develop a booklet that will be agreeable to patients, however, it is important to diminish the threat of stigma – by enabling the user to be seen in a positive light by others (Corrigan, 2004), by nurturing self-esteem and self-efficacy (Corrigan, 2004; Larson & Corrigan, 2010), by empowering patients via participation in self-care (Speer, Jackson, & Peterson, 2001), and by encouraging belief in treatment success (Meltzer, Bebbington, Brugha, Farrell, Jenkins, & Lewis, 2003; Corrigan, 2004).

Evidence-based approaches to mind/body education and "health behavior change" that also guided the development and delivery of this project included: the Stages of Change (Transtheoretical) Model (TTM), the Health Belief Model (HBM), *Pfizer Principles for Clear Health Communications* (Pfizer Inc., 2012), and expert advice for addressing patients' religion/spirituality.

CHAPTER THREE

METHODOLOGY

The purpose of this project was to create a research-based patient-friendly booklet that provides guidance with regard to psychological considerations that may be employed to enhance, or accelerate, the process of healing from illness. The content of this booklet was limited to research-based data and interventions that are highly ubiquitous and actionable, and with broad applicability (as apposed to being condition-specific).

To guide this endeavor, a study of important considerations, based upon the research and contributions of others, was performed (Chapter Two). The study focused on three areas: the prevalence and impact of mind-body maladies, the challenge of addressing psychological factors in Western health care, and approaches to mind-body education and care.

Foundational materials for these areas came from contemporary research-based teaching texts on “mind-body medicine,” “complementary and alternative medicine,” and “theories of health behavior change,” developed by leaders, researchers, and educators in these fields of study. These texts provided contemporary perspectives and key findings, and spawned ideas for additional threads of inquiry. These additional inquiries, performed online via the EBSCOhost, PsycINFO, ScienceDirect, and Google Scholar academic search engines, led to peer-reviewed journal articles and other expert sources that provided supplemental data, additional psychological considerations for healing, greater insights into physicians' and patients' "true" needs, and guidance for written health communications.

The distillation and presentation of this material into a patient-friendly booklet was a creative endeavor, guided by the findings of this study (Chapter Two). Text was written at about a ninth grade reading level, which was assessed via the Flesch-Kincaid Grade Level Scale included in Microsoft Word (2012). All "recommended readings," or online/community resources provided are generally recognized as reputable for their respective purposes. A list of references was also provided.

The size and shape of a booklet of this nature could assume a wide range of formats. There are some fundamental considerations: For broad readability, the Helvetica font was advised (per consultation with a local print shop owner), in size 14 (per Pfizer, 2012). Also, the booklet must be easy to carry and use, and relatively inexpensive to reproduce.

Beyond these considerations, taking a "form follows function" approach was determined to be most practical – i.e., creating the content first, then tailoring the size, shape, and appearance of the booklet, for purposes of professional presentation, accordingly. Per consultation with the graduate advisory committee, the project presented here (Chapter Four) is not the published version, but is presented for academic content.

CHAPTER FOUR

RESULTS

Mind Your Stressors

Considerations for Better Health and Faster Healing

Table of Contents

The Purpose of This Booklet

The signs of illness that your physician can observe, test for, and treat are only part of the picture. Each of us has a unique combination of stressors that can influence our mental and physical health in a wide variety of ways.

The purpose of this booklet is to increase your awareness of stressors that may be contributing to symptoms of illness, or undermining the body's natural ability to heal. Increasing this awareness empowers you to make changes – for yourself, or for someone you care for – that can significantly strengthen the body's natural healing processes. Over time, the ripple effect of these changes can also lead to a longer, happier life.

Are You Experiencing "Medically Unexplained Symptoms?"

You are not alone. Studies reveal that 50-80 percent of patients seen in primary care present symptoms for which no clear-cut organic cause is discovered.

For both patients and physicians, recurring medically unexplained symptoms (MUS) can be highly frustrating. This predicament is neither the fault of doctors nor patients. Medical knowledge is incomplete, and the complexity of illness and suffering is not fully represented by medical categories.

Increasing your awareness of stressors empowers you to make changes that can be helpful toward healing, or managing, "medically unexplained symptoms" as well. As you become more sensitive to, and honest about, how the choices you make daily are affecting your health, the answers you seek may be increasingly revealed.

The Difference Between "Acute" Stressors And "Chronic" Stressors

An "acute" stressor is short-term stressor, like an exam. The effects of an acute stressor typically subside in one to two hours.

A "chronic" stressor is one that is ongoing, or that frequently repeats. It may be a daily fear of being unable to cope with, or control, some aspect of your life. Memories of a traumatic event, worries about the future, and other highly intrusive thoughts are also considered chronic stressors.

Chronic stressors can wear on the body and increase your risk of illness. Some observed effects include (but are not limited to):

(1) Elevated cholesterol – a risk factor for developing heart disease;

(2) Elevated uric acid – a risk factor for developing gout, kidney stones, kidney disease;

(3) Increased inflammation – contributes to pain/swelling, breathing problems, digestive problems, memory problems, and more; and

(4) Suppressed immunity – to invading viruses, bacteria, tumors, and toxins – increasing your risk to a variety of illnesses.

Research reveals that people who develop serious illness are likely to have experienced higher levels of chronic stress in the preceding year.

Can you identify three chronic stressors (big or small, internal or external) that are presently affecting you?

1. ______________________________
2. ______________________________
3. ______________________________

Mind Your Stressors!

Increasing knowledge and skills relevant to a threatening situation (stressor) helps to increase self-efficacy and reduce fears. Make it a goal to face the stressor (in a healthy way), so you can move beyond it. Some empowering actions you might want to consider include (1) reading up on the topic, (2) attending a lecture, class, or support group, (3) observing the examples of others, and (4) seeking professional counseling and support (see pg. 63).

Simultaneously, mental activities that relax you, or improve your mood, can help to offset the deleterious effects of stressors. Some examples of stress-reducing mental activities that can be practiced daily – and whenever needed – include:

- Mindfulness Meditation (MM) – a calming practice of mindful awareness/contemplation.
- Positive Self-Talk – replacing negative inner dialogue (statements) with positive statements.

- Imagery – of a peaceful object or place, involving all the senses; may also be tailored to specific healing needs (i.e., vivid imagery of the healthy end state that you desire)
- Progressive relaxation – the systematic relaxation of muscle groups throughout the body; this practice is often used to create a relaxed and receptive state for mindfulness meditation or positive imagery, as well.
- Relaxing or uplifting music – positive in nature; alternatively, beginning with music that reflects your mood state and gradually moving toward music that is peaceful/positive (called entrainment).
- "Laughter" therapy – making a point of enjoying funny books, movies, people, or laughing just because!

Mental activities that relax you, or improve your mood, have been found to improve immunity and hormonal function, and reduce inflammation in the body. They can help to replenish your mind, body, and spirit, and to increase strength and resources for better health and faster healing. Frequent practice (for example, 20 minutes once or twice a day) produces better results.

Mind/body offerings such as these are increasingly being offered in various Western health care settings. To learn about offerings in your area, check online, and ask your health care provider. If you don't find a class nearby, however, don't let that stop you; a list of books that can help you get started on your own is offered below (see "Suggested Reading").

Be patient; give yourself some time to learn (several weeks), and to observe how it is working for you. If you find that a particular technique is having an undesirable effect, stop, and try something else.

Take a few moments now to ponder and answer the following questions:

Reflecting back on the chronic stressors you identified previously (pg. 50): Why do you think these stressors continue to affect you?

1. ____
2. ____
3. ____

What kind of information, knowledge, or skills might be helpful to you?

1. ____
2. ____
3. ____

What are some actions you could take to laugh more?

1. ____
2. ____
3. ____

What are some music selections that inspire peace, happiness, or fond memories for you?

1. ____
2. ____
3. ____

Consider loading your favorite uplifting music to the device of your choice, or asking a friend or loved one to create it for you.

Suggested Reading

Clark, D. A., & Beck, A. T. (2011). *The Anxiety and Worry Workbook: The Cognitive Behavioral Solution.* New York: Guilford Publications, Inc.

Cousins, N. (1981). *Anatomy of an Illness.* New York: Bantam Books.

This book is a classic on the benefits of laughter to health and healing.

Kabat-Zinn, J. (2005). *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness.* New York: Bantam Dell.

Researcher/clinician Jon Kabat-Zinn is a leader in the practice of Mindfulness Meditation (MM); this book provides an excellent foundation for getting started, and for tailoring MM to your needs.

Kabat-Zinn, J. (1995). *Wherever You Go, There You Are: Mindfulness Meditation in Everday Life.* New York: Hyperion.

Lorig, K., Holman, H., Sobel, D., Laurent, D., Gonzalez, V., & Minor, M. (2000). *Living a Healthy Life with Chronic Conditions: Self-management of Heart Disease, Arthritis, Diabetes, Asthma, Bronchitis, Emphysema & Others* (2nd ed.). Boulder, CO: Bull Publishing Company. An excellent resource for caregivers and patients alike; includes guidance for using imagery, progressive relaxation, and positive self-talk.

Rossman, M. (1989). *Healing Yourself: A Step-By-Step Program for Better Health Through Imagery*. New York: Pocket Books.

Dr. Rossman is a leading thinker/researcher of imagery in healing. This book continues to be recommended reading.

* * *

Some chronic stressors frequently linked to symptoms of illness, and with slower healing, are further described in the pages that follow. Taking steps to reverse these stressors can strengthen the body's natural healing processes. It may also help you to lead a happier, longer life.

"Buried" Emotions

All sentient (conscious, feeling) human beings are subject to thoughts and emotions that can negatively influence health. Naturally, it is desirable (and most healthful) to strive for positive thoughts, and for emotional balance. This is especially true if you are sick, or are managing a chronic condition. Emotional distress can increase perceptions of discomfort and pain. It can also undermine progress toward healing.

However, hiding from threatening thoughts and burying your emotions can actually prolong and increase their stressful effects. Sometimes these effects can manifest (appear) as physical symptoms, such as:

- Acute chest pain
- Chronic fatigue
- Chronic allergic reactions
- Chronic pain (especially in jaw or lower back)
- Concentration problems
- Headaches
- High blood pressure
- Insomnia
- Irritable bowel syndrome
- Loss of appetite
- Respiratory problems

People who have experienced traumatic events are more likely to experience these symptoms as well.

Rather than hiding from threatening thoughts and emotions, it is better to acknowledge them, give them a voice. There are a variety of healthy and productive ways to go about expressing your thoughts and emotions. You can:

- Write about them – in a personal notebook or journal.

  For those so inclined, poetry can be a great form of emotional expression, as well.
- Talk about them – with a compassionate friend or family member, or in the privacy of a compassionate therapist (see pg. 67). In many hospital settings, chaplain services are available for comfort and support as well; just ask.
- Pray about them – to God, the Power of the Universe (or other).

  Many hospitals also provide a 24-hour chapel for meditation and prayer.
- Paint them – express your thoughts and feelings visually.
- Have a good cry. Just let it all out.

Acknowledging your thoughts and feelings is not only healthier, it places you in a better position to address the threat, and get on with your life.

Take note: If threatening thoughts or emotions persist, or begin to feel overwhelming, be sure to mention this to your doctor. Our bodies go through a myriad of changes throughout our lives; it may be that a biological change, imbalance, or sensitivity is a contributing factor. Seeking the advice and support of a good therapist can be insightful, and helpful toward healing as well (see pg. 67).

Suggested Reading

Dossey, L. (1996). *Prayer Is Good Medicine.* San Francisco: Harper Collins.

Pennebaker, J. W. (1997). *Opening Up: The Healing Power of Expressing Emotions.* New York: Guilford Press.

Pennebaker, J. W. (2004). *Writing to Heal: A Guided Journal for Recovering From Trauma & Emotional Upheaval.* Oakland, CA: New Harbinger Publications, Inc.

Loneliness and Relationship Troubles

Are you lonely? Is there someone you would like to get along with better? Is there someone that you need to forgive?

Studies show that the lower the quantity or quality of relationships, the higher the risk of illness and death. Social isolation, in particular, greatly increases the risk of illness and death.

On the other hand, social connectedness is strongly associated with better health, and a longer life. Below are some specific recommendations and findings for your review:

(1) Spend time with and around others on a regular basis.

A moderate level of social interaction is most healthful. Excessive or negative social interaction may increase levels of anxiety and depression. However, what constitutes "excessive" varies by individual temperament, coping style, and the stress of other social/family issues. Just living with someone has been found to reduce the risk of recurring and fatal cardiac events.

(2) Join a club, church, or other group of interest.

Being an active member of a group, or a church, is linked to increased longevity and survivorship, as well. Outside activities and contacts of various kinds can be beneficial in their own ways. For ideas, some great places to look are your local newspaper, community center, senior center, college or adult school, and public library. If you have difficulties with getting "out and about" on your own, or have social anxiety, consider hiring a "personal assistant" to accompany you (also makes a great "gift" from the family). Your health and happiness are worth it!

(3) Invest in supportive relationships.

Supportive relationships are particularly healthful. Cobb (1976) first defined "social support" as "information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations." Another helpful definition was developed for a study by Thomas, Goodwin, and Goodwin (1985); in this study, "social support" was defined as "the presence of satisfying relationships with trusted individuals in whom the participants were able to confide." After reviewing numerous studies, Cobb (1976) found that social support (1) "buffered" the effects of stress for individuals in crisis, (2) reduced the level of medications required, (3) accelerated healing, and (4) increased compliance with prescribed medical treatments. Individuals with supportive, intimate relationships (e.g., spouse, family, close friends) receive the greatest health benefits. On the whole, these individuals report fewer injuries and chronic illnesses, heal faster, and live longer.

(4) Take action to repair or resolve relationship troubles.

While relationships are crucial to longevity, relationship-related challenges can be a major cause of chronic stress. This is especially true of intimate (close, familiar) relationships, as the bonds of intimate relationships can be extremely strong. When the connectedness of an intimate relationship is threatened or lost, the "separation distress" that results becomes a chronic stressor – until the conflict is resolved, or until the separation distress diminishes with time, perhaps facilitated by a new relationship. Chronically abrasive and unhappy marriages are linked to poor physical and psychological health, especially for individuals already in a susceptible state. Freeman (2009) further summarizes the research on "marital disruption" as follows:

> Marital disruption was found to be the single most powerful sociodemographic predictor of stress-related physical illness, with separated individuals reporting 30% more acute illness and physician visits than their married counterparts (Somers, 1979). With age, race, and income variables controlled, separated and divorced people still obtained the highest rates of acute medical problems, chronic medical

> conditions limiting social activity, and disabilities as compared with married people (Verbrugge, 1979). Separated and divorced individuals also had a higher rate of death from infectious diseases, including up to six times the number of deaths from pneumonia (Lynch, 1977) (p. 103).

Studies such as these strongly suggest that the state of your personal relationships need be taken seriously, especially when dealing with illness. For help with improving your relationships, consider seeking the help of a trained professional (see pg. 67).

Suggested Reading

Beck. A. (1989). *Love Is Never Enough: How Couples Can Overcome Misunderstandings, Resolve Conflicts, and Solve Relationship Problems Through Cognitive Therapy.* New York: Harper Collins.

McKay, M., Davis, M., & Fanning, P. (2009). *Messages: The Communication Skills Book* (3rd ed.). Oakland, CA: New Harbinger Publications, Inc.

Caregiving

Taking care of a chronically ill parent, child, sibling, or spouse is another common source of chronic stress that often continues for many years. Emotions commonly experienced by caregivers include guilt, anger, depression, and fear of the future – in relation to patient care, as well as for personal health. Over time, the emotional "wear and tear" of caregiving has been found to degrade immune function and increase inflammation in the body. Viral and upper respiratory infections are seen more frequently in this group. Caregivers are also more susceptible to the diseases of aging, such as Alzheimer's disease, cardiovascular disease, arthritis, type 2 diabetes, osteoporosis, certain cancers, physical frailty, functional decline, and periodontal disease.

Findings such as these strongly suggest that as a caregiver, it is very important to "mind your stressors." Some recommendations that can help are offered below.

- Increase your effectiveness.

  Acquire knowledge and skills for caring for a loved one with this condition or disease. Request information and advice from (1) your doctors, (2) agencies and non-profit organizations devoted to the disease, and (3) support groups. (Also see "Suggested Readings," below).

- For depression and relationship challenges, seek counseling (pg. 67).

  Dealing with chronic illness is often frustrating (for all parties involved). It is important to be able to communicate your thoughts and feelings in a positive and constructive way.

- Get help.

  Make use of services and community resources. Sometimes your medical insurance can help pay; some offerings may be free. Some services you might want to consider include in-home/nursing care, meal preparation/delivery (such as "Meals On Wheels," or prepared meals for weight management), grocery delivery services, transportation services, prescriptions by mail, and housekeeping. For miscellaneous errands and activities, and getting "out and about," consider hiring a "personal assistant" (for yourself or loved one; this also makes a great family "gift").

- Stay socially connected (see pg. 57). Social isolation is very unhealthy for the both of you.
- Practice stress-reduction techniques regularly (ideally once or twice a day; see pg. 50).

Suggested Reading

Lorig, K., Holman, H., Sobel, D., Laurent, D., Gonzalez, V., & Minor, M. (2000). *Living a Healthy Life with Chronic Conditions: Self-Management of Heart Disease, Arthritis, Diabetes, Asthma, Bronchitis, Emphysema & Others* (2nd ed.). Boulder, CO: Bull Publishing Company. This is an excellent resource for caregivers and patients alike.

Wilkinson, J. A. (1999). *A Family Caregiver's Guide to Planning and Decision Making for the Elderly*. Minneapolis: Fairview Publishing.

Other Resources

Family Caregiver Alliance: National Center on Caregiving

Visit online at http://caregiver.org.

Search online for your local "Area Agency on Aging."

The Death of a Loved One

The death of a spouse or a child is widely considered the most painful (and stressful) event a person can experience in life. Studies show that highly unhealthful effects (on immunity and hormones) can result, particularly during the first two months after loss. Continued effects have been found to persist at an "intermediate" level, improving gradually for up to 14 months later. Studies further suggest an increased likelihood of death among windows and widowers in bereavement – particularly among individuals with low socialization and support.

Healing from the loss of a loved one, both physically and emotionally, takes time. Sometimes it can feel overwhelming. It is important to allow yourself extra time to relax, to realize your loss, and to cry.

However, during this vulnerable time, it is also important to maintain (or develop) your social connectedness. It is healthy and healing to express your thoughts and feelings openly with others, and to accept their support when offered. Joining a bereavement support group can be also be helpful with healing, and for connecting with others faced with similar challenges. Becoming a part of a religious or spiritual community can increase much-needed social and behavioral support, as well. Sometimes the circumstances surrounding the death of a loved one can be complex and difficult to work through; if this is true for you, consider enlisting the help of a Grief Counselor or Therapist (p. 67).

Your sense of well-being is also influenced by your environment. Strive to create and spend time in uplifting places, infused with life. Also, as time progresses, take note of "triggers" that may be disruptive to healing. For example, if a photo in your front entry is triggering sadness, create a special place for it somewhere else, to visit when the moment is right. The holidays can be a particularly difficult time; plan ahead, and be extra good to yourself. You're worth it.

Suggested Reading

Kübler-Ross, E. (1997). *On Death and Dying.* New York: Scribner Classics

Hedtke, L., & Winslade, J. (2004). *Remembering Lives: Conversations With the Dying and the Bereaved.* Amityville, NY: Baywood Publishing Company, Inc.

Situational Stressors

There is ample research from the field of psychology (studies of the mind) to suggest that, beyond genetics and personal history, emotions and behaviors are highly situational. This finding is highly relevant as it pertains to your assessment of both public and personal stressors, as well as to the creation of new "situations" with psychological benefits to health. For example, studies show that attention to environmental stimuli – e.g., aesthetic (visual) appeal, windows/sunlight, orderliness, odor, temperature, and the sounds of a patient's environment – can help to reduce distress, promote a sense well-being, encourage social interaction and interest in activities, improve sleep, and encourage healing. The identification of situational "triggers" that precede unhealthful mental and physical behaviors is an important consideration; for example, Tanja-Kijkstra (2011) found that minimizing the view of medical equipment (tubes, monitors, etc.) is helpful in reducing patient stress. Conversely, triggers may also be used purposefully, as interventions. For example, music can trigger positive memories and moods and help to dispel loneliness and agitation – even among individuals with dementia. Findings such as these demonstrate that even small "situational" changes may be made that can have a positive influence on health and healing.

Take a few moments now to consider:

In what ways might your environment be changed to better support your health?

____

____

____

Think of a chronic stressor in your life. Can you identify a trigger that seems to precede it?

Stressor: ____

Trigger(s): ______________________________________

Can you take reasonable action to avoid this trigger? If so, what?

____

____

____

When unavoidable, can you think of a way to respond to this trigger, or situation, differently?

____

____

____

Cognitive-behavioral therapy (CBT) can be very helpful with overcoming situational stressors (see pg. 67).

Dishonesty / Self-Denial

Studies of "remarkable survivors" have described introspective journeys leading to increased autonomy (agency) and authenticity (truth) in their lives. Personal values and problem areas were clarified, changes were made, and increased freedom, harmony, self-efficacy, and acceptance resulted. As such, these individuals often came to view their illnesses as gifts.

Take a few moments now to ponder the following questions:

Can you think of one or more ways that you have <u>not</u> been authentic, or have been "living a lie?"

1. ____________________
2. ____________________
3. ____________________

In what ways (big or small) would like to be more authentic?

1. ____________________
2. ____________________
3. ____________________

How might you go about doing this?

1. ____________________
2. ____________________
3. ____________________

Consider Counseling/Therapy

There are some wonderful, caring people out there who have studied these topics in depth – made it their life's work – in order to help fellow human beings work through these challenges, and enjoy happier, healthier lives. Similar to the way you would consult with an attorney, or a personal trainer, or a hairstylist, utilizing the services of an expert can yield better, faster results.

Enlisting the support of a counselor, or therapist, can be beneficial to health and healing in several ways:

- Increasing knowledge and skills relevant to a threatening or disruptive stressor increases self-confidence and reduces fears.
- Expressing troublesome thoughts and emotions openly, honestly, and confidentially, reduces their energy-sapping, illness-producing effects, and helps you to move forward.
- Gaining the perspective of another on a challenging situation increases your ability to see other solutions that may be available to you.
- Having a supportive, good-hearted person "in your corner," looking out for your well-being, just feels good! Social support and positive emotions are powerful, natural "medicines" for health and healing.

How To Get Started

1. Call your insurance company, or visit the Member web site, to obtain a listing of providers in your area (usually by zip code). This information can be found on your insurance card.
2. Many therapists have personal web sites. Take a look at these and see what you think. Avoid making "snap" judgments about someone based upon a photo.

3. For those who might be a fit, call and ask to speak to them personally.
    a. Briefly describe (in just one or two sentences, if possible) the kind of support or guidance you are seeking. (Remember, you haven't hired this person yet!)
    b. Some questions you might want to ask include:
        i. His/her experience in this area
        ii. The kind of therapy, or approaches, offered
4. While the answers to these questions are important, what is just as important is how you relate to this person. After each phone call, ask yourself:
    - Do I have a good feeling about this person?
    - Do I think I will be comfortable working with him/her?

    If your answer to these questions is "yes" or "maybe":
5. Make an appointment. See how it goes. If you like this person, great – you're on your way. If not, that's okay too; you are free to move on and try someone else.

◆

"The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen."

– Elizabeth Kübler-Ross

References

Balint, M. (1964). *The doctor, his patient, and the illness.* New York: International Universities Press.

Bartrop, R. W., Lazarus, L., Luckhurst, E., Kiloh, L. G., & Penny, R. (1977). Depressed lymphocyte function after bereavement. *The Lancet, 309*(8016), 834-836.

Berkman, L. F., & Syme, S. L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents. *American Journal of Epidemiology, 109*(2), 186-204.

Bourgeois, M. S., Schulz, R., & Burgio, L. (1996). Interventions for caregivers of patients with Alzheimer's disease: A review and analysis of content, process, and outcomes. *The International Journal of Aging and Human Development, 43*(1), 35-92.

Breitling-Winkler, B. M. (2008). *Being true to self: The experience of congruence in cancer survivors.* Library and Archives Canada= Bibliothèque et Archives Canada.

Brennan, B. A. (2001). Adjustment to cancer – coping or personal transition. *Psycho-Oncology, 10*(1), 1-18.

Cartensen, L. L., Levenson, R. W., & Gottman, J. M. (1995). Emotional behavior in long-term marriage. *Psychology and Aging, 10*(1), 140-149.

Cobb, S. (1976). Presidential Address-1976. Social support as a moderator of life stress. *Psychosomatic Medicine, 38*(5), 300-314.

Coward, D. D. (1997). Constructing meaning from the experience of cancer. In *Seminars in Oncology Nursing, 13*(4), 248-251.

Cuddy, L. L., & Duffin, J. (2005). Music, memory, and Alzheimer's disease: Is music recognition spared in dementia, and how can it be assessed?. *Medical Hypotheses, 64*(2), 229-235.

Cunningham, A. J. (2003). The return to authenticity. *Advances in Mind-Body Medicine, 19*(2), 8-9.

Dijkstra, K., Pieterse, M., & Pruyn, A. (2006). Physical environmental stimuli that turn healthcare facilities into healing environments through psychologically mediated effects: Systematic review. *Journal of Advanced Nursing, 56*(2), 166-181.

Esterling, B. A., Kiecolt-Glaser, J. K., & Glaser, R. (1996). Psychosocial modulation of cytokine-induced natural killer cell activity in older adults. *Psychosomatic Medicine, 58*(3), 264-272.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Freeman, L. (2009). *Mosby's complementary & alternative medicine: A research-based approach* (3rd ed.). St. Louis, MO: Mosby, Inc.

Friedman, M., Rosenman, R. H., Carroll, V., & Tat, R. J. (1958). Changes in serum cholesterol and blood-clotting time in men subjected to cyclic variation of occupational stress. *Circulation, 17*(852), 852-861.

Glaser, R., & Kiecolt-Glaser, J. K. (2005). Stress-induced immune dysfunction: Implications for health. *Nature Reviews Immunology, 5*(3), 243-251.

Helsing, K. J., & Szklo, M. (1981). Mortality after bereavement. *American Journal* of Epidemiology, *114*(1), 41-52.

Helsing, K. J., Szklo, M., & Comstock, G. W. (1981). Factors associated with mortality after widowhood. *American Journal of Public Health*, *71*(8), 802-809.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science*, *241*(4865), 540-545.

House, J. S., Robbins, C., & Metzner, H. L. (1982). The association of social relationships and activities with mortality: Prospective evidence from the Tecumseh Community Health Study. *American Journal of Epidemiology*, *116*(1), 123-140.

Institute for Health and Aging. (1996). *Chronic care in America: A 21st century challenge.* Princeton, NJ: The Robert Wood Johnson Foundation.

Jemmott, J., Borysenko, M., Chapman, R., Borysenko, J., Mcclelland, D., Meyer, D., & Benson, H. (1983). Academic stress, power motivation, and decrease in secretion rate of salivary secretory immunoglobulin A. *The Lancet*, *321*(8339), 1400-1402.

Kasl, S. V., Cobb, S., & Brooks, G. W. (1968). Changes in serum uric acid and cholesterol levels in men undergoing job loss. *JAMA: The Journal of the American Medical Association*, *206*(7), 1500-1507.

Kessler, R. C., & McLeod, J. D. (1985). Social support and mental health in community samples. In: Cohen, S., Syme, S. L., (Eds.), *Social support and health.* New York: Academic Press.

Kiecolt-Glaser, J. K., Dura, J. R., Speicher, C. E., Trask, O. J., & Glaser, R. (1991). Spousal caregivers of dementia victims: Longitudinal changes in immunity and health. *Psychosomatic Medicine*, *53*(4), 345-362.

Kiecolt-Glaser, J. K., Malarkey, W. B., Chee, M., Newton, T., Cacioppo, J. T., Mao, H. Y., & Glaser, R. (1993). Negative behavior during marital conflict is associated with immunological down-regulation. *Psychosomatic Medicine, 55*(5), 395-409.

Kiecolt-Glaser, J. K., Glaser, R., Strain, E. C., Stout, J. C., Tarr, K. L., Holliday, J.E., & Speicher, C. E. (1986). Modulation of cellular immunity in medical students. *Journal of Behavioral Medicine*, *9*(1), 5-21.

Kiecolt-Glaser, J. K., Glaser, R., Williger, D., Stout, J., Messick, G., Sheppard, S., & Donnerberg, R. (1985). Psychosocial enhancement of immunocompetence in a geriatric population. *Health Psychology, 4*(1), 25.

Knight, B. G., Lutzky, S. M., & Macofsky-Urban, F. (1993). A meta-analytic review of interventions for caregiver distress: Recommendations for future research. *The Gerontologist*, *33*(2), 240-248.

Kroenke K., & Mangelsdorff, A. D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy, and outcome. *American Journal of Medicine, 86*(3), 262-266.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lorig, K., Holman, H., Sobel, D., Laurent, D., Gonzalez, V., & Minor, M. (2000). Living a healthy life with chronic conditions: Self-management of heart disease, arthritis, diabetes, asthma, bronchitis, emphysema and others (2nd ed.). Boulder, CO: Bull Publishing Company.

Magee, J. C., & Teachman, B. A. (2012). Distress and recurrence of intrusive thoughts in younger and older adults. *Psychology & Aging, 27*(1), 199-210.

Magee, W. L. (2005). Music therapy with patients in low awareness states: Approaches to assessment and treatment in multidisciplinary care. *Neuropsychological Rehabilitation, 15*(3-4), 522-536.

Malarkey, W. B., Kiecolt-Glaser, J. K., Pearl, D., & Glaser, R. (1994). Hostile behavior during marital conflict alters pituitary and adrenal hormones. *Psychosomatic Medicine, 56*(1), 41-51.

Maliski, S. L., Heilemann, M. V., & McCorkle, R. (2002). From" death sentence" to "good cancer": Couples' transformation of a prostate cancer diagnosis. *Nursing Research*, *51*(6), 391-397.

Moss, D. (2003). Mind-body medicine, evidence-based medicine, clinical psychophysiology, and integrative medicine. In: D. Moss, A. McGrady, T.C. Davies & I. Wickramasekera (Eds.), *Handbook of mind-body* *medicine for primary care* (pp. 3-18). Thousand Oaks, CA: Sage Publications.

Nettleton, S., Watt, I., O'Malley, L. Duffey, P. (2005). Understanding the narratives of people with medically unexplained illness. *Patient Education and Counseling, 56*(2), 205-210.

Orth-Gomer, K., & Johnson, J. V. (1987). Social network interaction and mortality: A six year follow-up study of a random sample of the Swedish population. *Journal of Chronic Diseases, 40*(10), 949-957.

Rahe, R. H., & Arthur, R. J. (1967). Stressful underwater demolition training: serum uric rate and cholesterol variability. *JAMA: The Journal of the American Medical Association, 202*(11), 1052-1054.

Rahe, R. H., Meyer, M., Smith, M., Kjaer, G., & Holmes, T. H. (1964). Social stress and illness onset. *Journal of Psychosomatic Research, 8*(1), *35-44.*

Renne, K. S. (1971). Health and marital experience in an urban population. *Journal of Marriage and the Family, 33*(2), 338-350.

Regier, D. A., Narrow, W. E., & Rae, D. S. (1990). The epidemiology of anxiety disorders: The epidemiologic catchment area (ECA) experience. *Journal of Psychiatric Research, 24(2),* 3-14.

Rider, M. S. (1985). Entrainment mechanisms are involved in pain reduction, muscle relaxation, and music-mediated imagery. *Journal of Music Therapy, 22*(4), 183-192.

Rotan, L. W., & Ospina-Kammerer, V. (2007). *Mindbody medicine*. New York, NY: Routledge.

Scheier, M., & Bridges, M. (1995). Person variables and health: Personality predispositions and acute psychological states as shared determinants for disease. *Psychosomatic Medicine*, *57*(3), 255-268.

Schleifer, S. J., Keller, S. E., Camerino, M., Thornton, J. C., & Stein, M. (1983). Suppression of lymphocyte stimulation following bereavement. *JAMA: The Journal of the American Medical Association*, *250*(3), 374-377.

Schoenbach, V. J., Kaplan, B. H., Fredman, L., & Kleinbaum, D. G. (1986). Social ties and mortality in Evans County, Georgia. *American Journal of Epidemiology*, *123*(4), 577-591.

Sherratt, K., Thornton, A., & Hatton, C. (2004). Music interventions for people with dementia: A review of the literature. *Aging & Mental Health*, *8*(1), 3-12.

Speer, P. W., Jackson, C. B., & Peterson, N. A. (2001). The relationship between social cohesion and empowerment: Support and new implications for theory. *Health Education & Behavior, 28*(6), 716-732.

Taylor, E. J. (2000). Transformation of tragedy among women surviving breast cancer. *Oncology Nursing Forum, 27*, 781-788.

Verbrugge, L. M. (1979). Marital status and health. *Journal of Marriage and the Family, 41*(267), 267-285.

Wegner, D. M. (1994). Ironic processes of mental control. *Psychological Review,101,* 34-52.

Welin, L., Svärdsudd, K., Ander-Peciva, S., Tibblin, G., Tibblin, B., Larsson, B., & Wilhelmsen, L. (1985). Prospective study of social influences on mortality: The study of men born in 1913 and 1923. *The Lancet*, *325*(8434), 915-918.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Failure to address the role of psychological factors in healing is contributing to chronic and escalating illness, and resulting in higher health care costs (Kathol & Gatteau, 2007). The need to address this issue more effectively is being increasingly recognized (Kathol & Gatteau, 2007). The challenge in Western health care is to find ways to make this happen.

In Western medicine, the physician's primary focus is physiological (Davies & Passon, 2003), and referrals to mental health professionals are typically offered only when allopathic approaches to healing have failed (Moss, 2003a). Simultaneously, many patients who may stand to benefit from psychological support are dismissive of the idea of seeking conventional psychological care (Larson, Corrigan, 2010; Corrigan, 2004). Without guidance, patients in need of psychological tools, or interventions, that might be conducive to healing are left to fend for themselves.

Though sufficient research exists, mind-body interventions that may be helpful to healing are underutilized in conventional (Western) medical care (Sobel, 2000; Friedman, Sobel, Meyers, Caudill & Benson, 1995). Studies reveal substantial public "needs," or demands, for mind-and-body offerings that integrate with their beliefs and values, are low in cost, are highly accessible, offer privacy, and enhance self-esteem (Astin, 1998, p. 1548; Starker, 1989, pp. 5-6). An easy-to-read booklet that offers psychological considerations for healing is uniquely well suited to address these needs. The purpose of this project was to develop this booklet.

As mind-body historian Anne Harrington observed, the present state of mind-body offerings is "a patchwork of approaches and understandings that pull in many different directions." (2008, p. 19). Therefore, a literature review to determine public needs, best practices, and forward thinking regarding both content and presentation was performed (Chapter Two). The study focused on three areas: the prevalence and impact of mind-body maladies, the challenge of addressing psychological factors in Western health care, and approaches to mind-body education and care.

The distillation and presentation of this material into a patient-friendly booklet was a creative endeavor, guided by the findings of this study. The scope of the material presented was limited to research-based data or interventions with reasonably broad applicability (as apposed to being condition-specific).

Conclusions

Several psychological/circumstantial factors are strongly associated with symptoms with illness: (1) suppression of threatening thoughts/emotions (Moss, 2003a), (2) feelings of frustration/low self-efficacy related to MUS and chronic illness (Nettleton, Watt, O'Malley & Duffey, 2003; Lorig et al., 2000), (3) low quantity or quality of relationships (House & Landis, 1988), (4) death of a loved one (Freeman, 2009), (5) being a caretaker (Freeman, 2009), (6) situational factors (e.g., appeal of environment; "triggers"), and (7) the need for greater autonomy and authenticity in one's life (Cunningham, 2003).

Some "barriers" to addressing psychological factors in Western health care include: Physicians report having insufficient time, training, and financial motivation to address psychological factors (Astin et al., 2006), male physicians are less likely to view psychological factors as important to treatment outcomes (Astin et al., 2006), and patients' concerns with pursuing psychological care stem from negative associations, or stereotypes, connected with the label of "mental illness," and the fear of negative repercussions related to public and/or self-stigma (Corrigan, 2004; Larson & Corrigan, 2010). The use of a patient booklet circumvents many of the concerns voiced by physicians, and integrates easily into the primary care setting. However, to develop a booklet that will be agreeable to patients, it is important to diminish the threat of stigma – by enabling the user to be seen in a positive light by others (Corrigan, 2004), by nurturing self-esteem and self-efficacy (Corrigan, 2004; Larson & Corrigan, 2010), by empowering patients via participation in self-care (Speer, Jackson, & Peterson, 2001), and by encouraging belief in treatment success (Meltzer, Bebbington, Brugha, Farrell, Jenkins, & Lewis, 2003; Corrigan, 2004).

Evidence-based approaches to mind/body education and "health behavior change" also guided the development and delivery of this project. They included the Stages of Change (Transtheoretical) Model (TTM), the Health Belief Model (HBM), *Pfizer Principles for Clear Health Communications* (Pfizer Inc., 2012), and expert advice for addressing patients' religion/spirituality.

Recommendations

Testing with sample patient groups for feedback is recommended. Experimentation and feedback will be required to determine size/shape/graphics for professional presentation as well. The content offered in this patient booklet could later be tailored to specific groups of individuals, such as seniors, children (girls/boys), men, women, specific ethnic groups, or individuals with specific health problems. The booklet should also be made available to download in electronic format. In a healthcare setting, combining it with information on specific mind-body or stress management classes offered at that facility would be also be beneficial.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., DSM-IV-TM).* Washington, DC: Author.

Aronowitz, R. A. (2001). When do symptoms become a disease? *Annals of Internal Medicine, 134*(9), 803-808.

Astin, J. A., Soeken, K., Sierpina, V. S., & Clarridge, B. R. (2006). Barriers to the integration of psychosocial factors in medicine: Results of a national survey of physicians. *The Journal of the American Board of Family Medicine*, *19*(6), 557-565.

Baehr, E. & Rosenfeld, J. P. (2003). Mood Disorders. In: D. Moss, A. McGrady, T. C. Davies & I. Wickramasekera (Eds.), *Handbook of mind-body medicine for primary care* (pp. 377-392). Thousand Oaks, CA: Sage Publications.

Bakal, D., Coll, P. & Schaefer, J. (2008). Somatic awareness in the clinical care of patients with body distress symptoms. *BioPsychoSocial Medicine*, *2*(1), 6.

Balint, M. (1964). *The doctor, his patient, and the illness.* New York: International Universities Press.

Bandura, A. (1997). *The exercise of control.* New York: W. H. Freeman.

Bartrop, R. W., Lazarus, L., Luckhurst, E., Kiloh, L. G., & Penny, R. (1977). Depressed lymphocyte function after bereavement. *The Lancet*, *309*(8016), 834-836.

Berkman, L. F., & Syme, S. L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents. *American Journal of Epidemiology, 109*(2), 186-204.

Bourgeois, M. S., Schulz, R., & Burgio, L. (1996). Interventions for caregivers of patients with Alzheimer's disease: A review and analysis of content, process, and outcomes. *The International Journal of Aging and Human Development, 43*(1), 35-92.

Breitling-Winkler, B. M. (2008). *Being true to self: The experience of congruence in cancer survivors*. Library and Archives Canada = Bibliothèque et Archives Canada.

Brennan, B. A. (2001). Adjustment to cancer – coping or personal transition. *Psycho-Oncology, 10*(1), 1-18.

Brown, J. W., Robertson, L. S., Kosa, J. & Alpert, J. J. (1971). A study of general practice in Massachusetts. *JAMA: The Journal of the American Medical Association, 216*, 301-306.

Bucks, R. S., Cruise, K. E., Skinner, T. C., Loftus, A. M., Barker, R. A., & Thomas, M. G. (2011). Coping processes and health-related quality of life in Parkinson's disease. *International Journal Of Geriatric Psychiatry, 26*(3), 247-255.

Cancer Treatment Centers of America. (2011). *What is mind-body medicine?* Retrieved from http://www.cancercenter.com/complementary-alternative-medicine/mind-body-medicine.cfm

Cartensen, L. L., Levenson, R. W., & Gottman, J. M. (1995). Emotional behavior in long-term marriage. *Psychology and Aging, 10*(1), 140-149.

Centre for Stress Management. (2011). *Definitions of stress.* Retrieved from http://www.managingstress.com/articles/definition.htm

Champion, V. L., & Skinner, C. S. (2008). The Health Belief Model. In: K. Glanz, B. K. Rimer, & K. Viswanath (Eds). Health behavior and health education: *Theory, research, and practice* (pp. 45-65). San Francisco, CA: Jossey-Bass.

Cobb, S. (1976). Presidential Address-1976. Social support as a moderator of life stress. *Psychosomatic Medicine*, *38*(5), 300-314.

Corrigan, P. (2004). How stigma interferes with mental health. *American Psychologist, 59*(7), 614-625.

Coward, D. D. (1997). Constructing meaning from the experience of cancer. In *Seminars in Oncology Nursing*, *13*(4), 248-251.

Cuddy, L. L., & Duffin, J. (2005). Music, memory, and Alzheimer's disease: Is music recognition spared in dementia, and how can it be assessed?. *Medical Hypotheses*, *64*(2), 229-235.

Cunningham, A. J. (2003). The return to authenticity. *Advances in Mind-Body Medicine*, *19*(2), 8-9.

Davies, M., & Palsson, O. S. (2003). Medical education for mind-body medicine. In: D. Moss, A. McGrady, T.C. Davies & I. Wickramasekera (Eds.), *Handbook of mind-body medicine for primary care* (pp. 443-448). Thousand Oaks, CA: Sage Publications.

Davies, T. C., & deGruy, F. V. (2003). Common problems in primary care: The need for a new biopsychosocial and psychophysiological model. In: D. Moss, A. McGrady, T.C. Davies & I. Wickramasekera (Eds.), *Handbook of mind-body medicine for primary care* (pp. ix-xix). Thousand Oaks, CA: Sage Publications.

deGruy, F. V., III. (1996). *Mental health care in the primary care setting.* Washington, DC: Institute of Medicine, National Academy Press.

Dijkstra, K., Pieterse, M., & Pruyn, A. (2006). Physical environmental stimuli that turn healthcare facilities into healing environments through psychologically mediated effects: Systematic review. *Journal of Advanced Nursing, 56*(2), 166-181.

Eisenberg, D. M., Davis, R. B., Ettner, S., Appel, S., Wilkey, S., Van Rompay, M., et al., (1998). Trends in alternative medicine use in the United States, 1990-1997: Results of a follow-up national survey. *JAMA: Journal of the American Medical Association, 280*, 1569-1575.

Esterling, B. A., Kiecolt-Glaser, J. K., & Glaser, R. (1996). Psychosocial modulation of cytokine-induced natural killer cell activity in older adults. *Psychosomatic Medicine*, *58*(3), 264-272.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Freeman, L. (2009). *Mosby's complementary & alternative medicine: A Research-based approach* (3rd ed.). St. Louis, MO: Mosby, Inc.

Friedman, M., Rosenman, R. H., Carroll, V., & Tat, R. J. (1958). Changes in serum cholesterol and blood-clotting time in men subjected to cyclic variation of occupational stress. *Circulation, 17*(852), 852-861.

Friedman, R., Sobel, D., Meyers, P., Caudill, M., & Benson, H. (1995). Behavioral medicine, clinical health psychology, and cost offset. *Health Psychology, 14*(6), 509-518.

Fries, J. F., Koop, C. E., Beadle, C. E., Cooper, P. P., England, M. J., Greaves, R. F., et al. (1993). Reducing health care costs by reducing the need and demand for medical services. *New England Journal of Medicine*, *329*(5), 321-325.

Glanz, K., Rimer, B. K., & Viswanath, K., (2008). Health behavior and health education: Theory, research, and practice (4th ed.). San Francisco, CA: Jossey-Bass.

Glaser, R., & Kiecolt-Glaser, J. K. (2005). Stress-induced immune dysfunction: Implications for health. *Nature Reviews Immunology, 5*(3), 243-251.

Gilkey, M., & Garcia, C. (2010). What do you think of when you think of patient education? An interview with Kate Lorig. *Health Promotion Practice, 11*(2), 169-172.

Goleman, D. & Gurin, J. (1993). *Mind/body medicine: How to use your mind for better Health.* New York: Consumer Reports Books.

Greenley, J. R., Mechanic, D., & Cleary, P. (1987). Seeking help for psychological problems: A replication and extension. *Medical Care, 25,* 1113-1128.

Harvard School of Public Health on Behalf of The World Health Organization and The World Bank. (1999). The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in1990 and projected to 2020. Boston, MA: Harvard University Press.

Helsing, K. J., & Szklo, M. (1981). Mortality after bereavement. *American Journal* of Epidemiology, *114*(1), 41-52.

Helsing, K. J., Szklo, M., & Comstock, G. W. (1981). Factors associated with mortality after widowhood. *American Journal of Public Health*, *71*(8), 802-809.

Hoffman, C., Rice, D., & Sung, H. (1996). Persons with chronic conditions: Their prevalence and costs. *JAMA: Journal of the American Medical Association*, *276*(18), 1473-1479.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science*, *241*(4865), 540-545.

House, J. S., Robbins, C., & Metzner, H. L. (1982). The association of social relationships and activities with mortality: Prospective evidence from the Tecumseh Community Health Study. *American Journal of Epidemiology*, *116*(1), 123-140.

Institute for Health and Aging. (1996). *Chronic care in America: A 21st century challenge.* Princeton, NJ: The Robert Wood Johnson Foundation.

Jemmott, J., Borysenko, M., Chapman, R., Borysenko, J., Mcclelland, D., Meyer, D., & Benson, H. (1983). Academic stress, power motivation, and decrease in secretion rate of salivary secretory immunoglobulin A. *The Lancet, 321*(8339), 1400-1402.

Kasl, S. V., Cobb, S., & Brooks, G. W. (1968). Changes in serum uric acid and cholesterol levels in men undergoing job loss. *JAMA: The Journal of the American Medical Association, 206*(7), 1500-1507.

Kathol, R. & Gateau, S. (2007). *Healing body and mind: A critical issue for health care reform.* Westport, CT: Praeger Publishers.

Kessler, R. C., & McLeod, J. D. (1985). Social support and mental health in community samples. In: Cohen, S., Syme, S. L., (Eds.), *Social support and health.* New York: Academic Press.

Kiecolt-Glaser, J. K., Dura, J. R., Speicher, C. E., Trask, O. J., & Glaser, R. (1991). Spousal caregivers of dementia victims: Longitudinal changes in immunity and health. *Psychosomatic Medicine, 53*(4), 345-362.

Kiecolt-Glaser, J. K., Malarkey, W. B., Chee, M., Newton, T., Cacioppo, J. T., Mao, H. Y., & Glaser, R. (1993). Negative behavior during marital conflict is associated with immunological down-regulation. *Psychosomatic Medicine, 55*(5), 395-409.

Kiecolt-Glaser, J. K., Glaser, R., Strain, E. C., Stout, J. C., Tarr, K. L., Holliday, J.E., & Speicher, C. E. (1986). Modulation of cellular immunity in medical students. *Journal of Behavioral Medicine*, *9*(1), 5-21.

Kiecolt-Glaser, J. K., Glaser, R., Williger, D., Stout, J., Messick, G., Sheppard, S., & Donnerberg, R. (1985). Psychosocial enhancement of immunocompetence in a geriatric population. *Health Psychology, 4*(1), 25.

Knight, B. G., Lutzky, S. M., & Macofsky-Urban, F. (1993). A meta-analytic review of interventions for caregiver distress: Recommendations for future research. *The Gerontologist*, *33*(2), 240-248.

Kroenke K., & Mangelsdorff, A. D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy, and outcome. *American Journal of Medicine, 86*(3), 262-266.

Larson, J. E., & Corrigan, P. W. (2010). Psychotherapy for self-stigma among rural clients. *Journal of Clinical Psychology: In Session, 66*(5), 524-536.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lorig, K., Holman, H., Sobel, D., Laurent, D., Gonzalez, V., & Minor, M. (2000). Living a healthy life with chronic conditions: Self-management of heart disease, arthritis, diabetes, asthma, bronchitis, emphysema and others (2nd ed.). Boulder, CO: Bull Publishing Company.

Lyon, D. E., & Tayor, A. G. (2003). Nursing education for mind-body nursing. In: D. Moss, A. McGrady, T.C. Davies, & I. Wickramasekera (Eds.), Handbook of mind-body medicine for primary care (pp. 449-456). Thousand Oaks, CA: Sage Publications.

Magee, J. C., & Teachman, B. A. (2012). Distress and recurrence of intrusive thoughts in younger and older adults. *Psychology & Aging, 27*(1), 199-210.

Magee, W. L. (2005). Music therapy with patients in low awareness states: Approaches to assessment and treatment in multidisciplinary care. *Neuropsychological Rehabilitation*, *15*(3-4), 522-536.

Mahler, H. (1977). The staff of Aesculapius. *World Health*, November.

Malarkey, W. B., Kiecolt-Glaser, J. K., Pearl, D., & Glaser, R. (1994). Hostile behavior during marital conflict alters pituitary and adrenal hormones. *Psychosomatic Medicine, 56*(1), 41-51.

Maliski, S. L., Heilemann, M. V., & McCorkle, R. (2002). From" death sentence" to "good cancer": Couples' transformation of a prostate cancer diagnosis. *Nursing Research*, *51*(6), 391-397.

Meltzer, H., Bebbington, T., Brugha, T., Farrell, M., Jenkins, R., & Lewis, H. (2003). The reluctance to seek treatment for neurotic disorders. *International Review of Psychiatry*, *15,* 123-128.

Moss, D. (2003). Mind-body medicine, evidence-based medicine, clinical psychophysiology, and integrative medicine. In: D. Moss, A. McGrady, T.C. Davies & I. Wickramasekera (Eds.), *Handbook of mind-body* *medicine for primary care* (pp. 3-18). Thousand Oaks, CA: Sage Publications.

Moss, D. (2003). Anxiety disorders. In: D. Moss, A. McGrady, T.C. Davies & I. Wickramasekera (Eds.), *Handbook of mind-body medicine for primary care* (pp. 359-373). Thousand Oaks, CA: Sage Publications.

Moss, R. (1995). *US gov't releases major report on alternative medicine.* Retrieved from http://www.ralphmoss.com/chant2.html

National Institutes of Health's National Center for Complementary and Alternative Medicine. (2010). Retrieved from http:/ccam.nih.gov/health/whatiscam

Nettleton, S., Watt, I., O'Malley, L. Duffey, P. (2005). Understanding the narratives of people with medically unexplained illness. *Patient Education and Counseling, 56*(2), 205-210.

Orth-Gomer, K., & Johnson, J. V. (1987). Social network interaction and mortality: A six year follow-up study of a random sample of the Swedish population. *Journal of Chronic Diseases, 40*(10), 949-957.

Paul, A. (2001). Self-help: Shattering the myths. *Psychology Today*, March.

Pfizer Inc. (2012). *How do the principles of clear health communication apply to written communication?* Retrieved from http:/www.pfizerhealthliteracy.com/publichealthprofessionals/HowDoPrinciple.aspx

Post, S. G., Puchalski, C., & Larson, D. (2000). Physicians and patient spirituality: Professional boundaries, competence, and ethics. *Annals of Internal Medicine, 132,* 578-583.

Rahe, R. H., & Arthur, R. J. (1967). Stressful underwater demolition training: serum uric rate and cholesterol variability. *JAMA: The Journal of the American Medical Association, 202*(11), 1052-1054.

Rahe, R. H., Meyer, M., Smith, M., Kjaer, G., & Holmes, T. H. (1964). Social stress and illness onset. *Journal of Psychosomatic Research, 8*(1), *35-44.*

Renne, K. S. (1971). Health and marital experience in an urban population. *Journal of Marriage and the Family, 33*(2), 338-350.

Regier, D. A., Narrow, W. E., & Rae, D. S. (1990). The epidemiology of anxiety disorders: The epidemiologic catchment area (ECA) experience. *Journal of Psychiatric Research, 24(2),* 3-14.

Rider, M. S. (1985). Entrainment mechanisms are involved in pain reduction, muscle relaxation, and music-mediated imagery. *Journal of Music Therapy, 22*(4), 183-192.

Rimer, B. K., & Glanz, K. (2005). *Theory at a glance: A guide for health promotion practice.* U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute.

Rotan, L. W., & Ospina-Kammerer, V. (2007). *Mindbody medicine.* New York, NY: Routledge.

Saybrook University. (2011). Retrieved from http://www.saybrook.edu/mbm/academicprograms.

Scheier, M., & Bridges, M. (1995). Person variables and health: Personality predispositions and acute psychological states as shared determinants for disease. *Psychosomatic Medicine*, *57*(3), 255-268.

Schleifer, S. J., Keller, S. E., Camerino, M., Thornton, J. C., & Stein, M. (1983). Suppression of lymphocyte stimulation following bereavement. *JAMA: The Journal of the American Medical Association*, *250*(3), 374-377.

Schoenbach, V. J., Kaplan, B. H., Fredman, L., & Kleinbaum, D. G. (1986). Social ties and mortality in Evans County, Georgia. *American Journal of Epidemiology*, *123*(4), 577-591.

Sherratt, K., Thornton, A., & Hatton, C. (2004). Music interventions for people with dementia: A review of the literature. *Aging & Mental Health*, *8*(1), 3-12.

Siegler, M., & Osmond, H. (1974). *Models of madness, models of medicine.* New York: Macmillan.

Sobel, D. (2000). Mind matters, money matters: The cost-effectiveness of mind/body medicine. *JAMA: Journal of the American Medical Association*, *284*(13), 1705.

Speer, P. W., Jackson, C. B., & Peterson, N. A. (2001). The relationship between social cohesion and empowerment: Support and new implications for theory. *Health Education & Behavior, 28*(6), 716-732.

Starker, S. (1989/2002). *Oracle at the supermarket; The American preoccupation with self-help books.* New Brunswick: Transaction Publishers.

Taylor, E. J. (2000). Transformation of tragedy among women surviving breast cancer. *Oncology Nursing Forum, 27*, 781-788.

Verbrugge, L. M. (1979). Marital status and health. *Journal of Marriage and the Family, 41*(267), 267-285.

Wegner, D. M. (1994). Ironic processes of mental control. *Psychological Review, 101,* 34-52.

Welin, L., Svärdsudd, K., Ander-Peciva, S., Tibblin, G., Tibblin, B., Larsson, B., & Wilhelmsen, L. (1985). Prospective study of social influences on mortality: The study of men born in 1913 and 1923. *The Lancet*, *325*(8434), 915-918.

Wickramasekera, I. (2003). The high risk model of threat perception and the Trojan horse role induction: Somatization and psychophysiological disease. In: D. Moss, A. McGrady, T.C. Davies & I. Wickramasekera (Eds.), *Handbook of mind-body medicine for primary care* (pp. 19-42). Thousand Oaks, CA: Sage Publications.

Wolsko, P., Eisenberg, D. M., Davis, R. B., & Phillips, R. S. (2004). Use of mind–body medical therapies: Results of a national survey. *Journal of General Internal Medicine (19)*, 43-50.

World Health Organization (2012). Retrieved from http://www.who.int/healthinfo/global_burden_disease/projection