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BOOK REVIEW

Serlin, I. A., & DiCowden, M. A. (Eds.). (2007). *Whole person healthcare: Humanizing healthcare* (Vol. 1). Westport, CT: Praeger.

Serlin, I. A., Rockefeller, K., & Brown, S. S. (Eds.). (2007). *Whole person healthcare: Psychology, spirituality, & health* (Vol. 2). Westport, CT: Praeger.

Serlin, I. A., Sonke-Henderson, J., Brandman, R., & Graham-Pole, J. (Eds.). (2007). *Whole person healthcare: The arts & health* (Vol. 3). Westport, CT: Praeger. Three Volumes, 1128 pages, $300.00 (hardcover).

Susan Gordon
National University, College of Letters and Sciences
Southbury Clinic for Traditional Medicines

This book review critically evaluates the *Whole Person Healthcare* (WPH) series. These 3 volumes advance a *biopsychosocialspiritual* model of the person and a holistic, integrative, multidisciplinary, multicultural, evidence-based approach to healthcare that addresses the complex interaction of these dimensions of health and illness. What is the place of WPH in the new medical continuum? Moving us away from the Cartesian dualism of scientific materialism towards a more humanistic paradigm, WPH focuses on issues of existential meaning in illness, as well as the psychological, emotional, imaginal, metaphorical, and symbolic element of being human through the expressive and creative arts. The constructs *horizontal integration* and *practice as taught* are introduced as an answer to our current crisis in clinical practice and public policy towards humanizing healthcare in the emerging model of collaborative care.

Whole person healthcare, as advanced by this series, is an approach that addresses the complex interaction of mental, physical, and spiritual

Correspondence should be addressed to Susan Gordon, Ph.D., Southbury Clinic for Traditional Medicines, 900 Main Street South, Southbury, CT 06488. E-mail: susan.gordon@snet.net

dimensions of health and illness through mind–body therapies that deal with the person in his or her setting, rather than in terms of isolated disease entities or body parts. This approach integrates behavior, cognition, and consciousness,[1] takes into account the impact of lifestyle on health issues, educates patients to be informed consumers who practice prevention and self-care, relies on experiential and theoretical learning, and utilizes symbolic and nonverbal, as well as linear and verbal, modes of expression, data gathering, and verification in research and clinical practice. Considering the person within the context of his or her worldview, this approach seeks to understand the *meaning* of a patient's symptoms, as well as their biological and behavioral causes, and empower the person to reduce stress, and enhance wellness, personal effectiveness, and quality of life (pp. xvii–xxiii).

This 3-volume series advances a *biopsychosocialspiritual* model of the person and a holistic, integrative, multidisciplinary, multicultural, evidence-based approach to healthcare. Although many "integrative" approaches today focus mainly on the body; helping the person to palliate physical symptoms, manage emotional distress, and improve functional status, they do not address the person's thoughts, beliefs, and existential meanings that are inextricably linked to deeper underlying issues that touch the mind, heart, and spirit. The whole person paradigm adds the spiritual, transcendent, or vertical dimension of personality[2] to the *biopsychosocial* model currently being advanced at the levels of clinical practice and public policy (Levant & Heldring, 2007; Paige, 2006; Serlin, 2001; Serlin et al., 2001).

What makes these books worthy of a review and a read, by both clinicians and consumers of healthcare services, is that they present a wide range of historical, theoretical, and practical examples from hospital-based,

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[1]William James linked the "sense of self" with our experience of the stream of consciousness. James (1890, 1902, 1904) defined consciousness as a field with a focus and a margin, a plurality of waking and subliminal states, and pure experience embodied in feeling and sensation.

[2]The spiritual, transcendent, or vertical dimension of personality refers to the expansion and contraction of consciousness; or embodied feelings and sensations in pure experience. We live not only along the lifespan horizontally, but in an ever-expanding and contracting experience of states along a vertical plane in the immediate moment (Gordon, 2007). In vertical moments in which one's sense of self is unscreened and undivided by the symbols and definitions of thought, the person may experience expansiveness, a deeper quality of being, and transcendent actualization or self-realization through peak or mystical states (Maslow, 1971). This subjective, qualitative experience depends on inward change in the intensity of the moment. The essence of the spiritual or the divine is often revealed through the experiences of creativity, intuition, and timelessness in existential time (Berdyaev, 1944). Existential moments are a dynamic fusion of experience within us, resulting from a dialectical process involving a tension producing conflict, out of which the sense of self emerges (May, 1975).

complementary and alternative (CAM)[3] mind–body therapies, and define a role for humanistic psychology and the expressive and creative arts[4] in transforming the way healthcare is practiced. The preface by David Spiegel, MD, medical director of the Center for Integrative Medicine at Stanford University Medical Center and the foreword by Dean Ornish, MD, founder and president of the Preventive Medicine Research Institute speak to the timeliness of this work. The series' general editor, Ilene Serlin, PhD, ADTR, volume editors: Marie DiCowden, PhD, Kirwan Rockefeller, PhD, Stephen S. Brown, Jill Sonke-Henderson, Rusti Brandman, PhD, John Graham-Pole, MD, as well as contributing authors, advocate collaboration between conventional, traditional, and complementary practices among healthcare professionals and some the therapeutic use of the arts to help patients access the embodied, self-actualizing dimension of their personality in the healing process.[5]

What is the place of whole person healthcare in the new medical continuum? As a psychologist schooled in existential phenomenology, the history and philosophy of psychology, and the person-centered approach to science, I believe that scientific materialism, reductionism, and evidence-based practice are a subset of holism and a complement to the intersubjective laboratory of the lived world. Quantitative analysis of single variables presents a fragmented and unrealistic view of the person. A lack of statistical evidence does not imply a lack of clinical evidence. Although evidence-based study is didactic, it is also myopic. It gives one a point of reference, however limited in its application to living systems.

Second, as the research director of a naturopathic medical clinic for the past 15 years, I introduce the construct *horizontal integration* as an answer to our current healthcare crisis. A healthcare model that is vertically

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[3]The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as:

> A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of "conventional medicine." Conventional medicine is medicine as practiced by holders of M.D. [medical doctor] or D.O. [doctor of osteopathy] degrees and by their allied health professionals, such as physical therapists, psychologists, and registered nurses. (Retrieved 2/9/08 from http://nccam.nih.gov/health/whatis cam/)

[4]Expressive and creative arts therapies include art, music, dance, poetry, drama, and psychodrama. Each discipline has its own professional association(s) and practices.

[5]Embodiment is our kinesthetic awareness of the body as the vehicle through which we experience the lived world. Physical and mental states, as reciprocal fields of interacting events (Sperry, 1992), form the person's immediate experience.

integrated is a top-down system where conventional medical practitioners[6] determine the necessity and efficacy of integrating CAM therapies into clinical practice that they may not have formally studied; whereas in a horizontally integrated model, conventional and traditional or whole medical systems providers,[7] who have formal education in these disciplines, work together as equal collaborators. This construct, central to my review of Volume 1, was, I believe, the implied next step that the White House Commission on CAM Policy (WHCCAMP, 2002), under the direction of James Gordon, MD, and others envisioned in their commitment to the responsible and safe stewardship of collaborative medicine in the *Final Report.*[8] Volumes 2 and 3 discuss the rationale and efficacy of integrating the whole person paradigm into clinical practice and public policy.

VOLUME ONE: HUMANIZING HEALTHCARE

In *Humanizing Healthcare*, Marie DiCowden, PhD, lays a foundation of definitions and practices of integrative care. She argues that instead of the profit-driven medical care delivery system in which unregulated fees for service, reimbursement through managed care, and costly defensive medicines complicate the burden to healthcare consumers, developing a *whole person* system will reduce the cost of healthcare and optimize the person's level

[6]Conventional refers to allopathic, osteopathic, dental, nursing, pharmacy, and allied health professionals.

[7]CAM practices have been grouped into four domains: (a) biologically based practices, (b) energy therapies, (c) manipulative and body-based methods, and (d) mind–body medicine. A once-fifth domain, "alternative medical systems," now classified as "whole medical systems," is built upon complete systems of theory and practice. They include: (a) homeopathic medicine, (b) naturopathic medicine, (c) traditional Chinese medicine (TCM), and (d) Ayurvedic medicine. The terms "Traditional" and "Whole medical" are synonymous (U.S. Department of Health and Human Services, FDA, 2006).

[8]The White House Commission on Complementary and Alternative Medical Policy (WHCCAMP, 2002) and the Federation of State Medical Boards have attempted to develop uniform national guidelines for the education and training of conventional practitioners in CAM (i.e., American Board of Holistic Medicine's certification exam). Challenges have included: "lack of educational standardization within professions, absence of a clearly delineated scope of practice, funding, and resistance from CAM and conventional professions and organizations" (WHCCAMP, 2002, p. 64). In its parting statement, the WHCCAMP voiced the concern that education and training of conventional practitioners in CAM through continuing education with content appropriate for all practitioners who provide CAM services and products are *not sufficient to enhance and protect the public's health and safety*. Thus, this report may best be best appreciated as a first attempt to organize CAM within a hospital-based environment to provide a stepping stone toward implementing a horizontally integrated healthcare system.

of functioning. In chapter 1, "Healthcare for the twenty-first century," DiCowden, the executive director and CEO of the Biscayne Institutes of Health and Living, gives the example of her community-based model combining integrative primary care, rehabilitation, and wellness: "While patients receive Western traditional [conventional][9] services of physical, occupational, and speech therapy... they can avail themselves of biofeedback, acupuncture, and herbs integrated with their allopathic physicians' treatment" (pp. 13–14). Services are provided by "two allopathic internists, one of whom is also board certified as a cardiologist, a licensed Chinese medicine practitioner[10] who also holds a degree in naturopathy, and a psychologist with a specialty in behavioral medicine and rehabilitation" (pp. 17). Yoga, tai chi, meditation, and religious–spiritual practices may also be integrated into treatment protocols. Although DiCowden views health as a shared social responsibility, her clinic is an example of vertically integrated care.

The strength of volume 1 is found in chapter 2, "Defining healthcare: Paradigm shifting without a clutch." Among the many arguments advanced by William Benda, MD, and Jeannette Gallagher, ND, they make the salient points that the crisis and political upheaval in our healthcare system is historically due to there being *no* standard of training in integrative medicine;[11] second, although the scientific method has utility, many interventions cannot be studied this way because there are myriad confounding factors and interactions that cannot be taken into account. For example, although synthetic drugs are designed to have a single active ingredient, natural pharmaceuticals are composed of many active ingredients. Much of prescribed pharmacy today operates via unknown mechanisms with difficult-to-anticipate side effects and long-term issues. Instead of trying to repair the current system, Benda and Gallagher suggest a redefinition of its ideology to promote equitable universal access with focus on disease prevention, treatment, and cure. They advocate that decisions regarding the provision of healthcare services not originate in the medical and reimbursement sectors, but become social contracts between individuals, providers, hospitals, academic institutions, corporations, communities, and governmental agencies. They envision a healthcare system in which providers offer prevention and treatment; academic institutions develop programs that promote synergistic

[9]Allopathic medicine is "conventional." Naturopathic medicine is "traditional."

[10]A license to practice acupuncture (Lac, not OMD) and a license to practice naturopathic medicine (ND) are needed to legally practice these disciplines in the State of Florida.

[11]William Benda, who is a board member of the American Association of Naturopathic Physicians (AANP), advocates the emerging status of naturopathic physicians nationally be included in the modern integrative center to responsibly steward this collaboration.

training in all aspects of medicine, nursing, pharmacy, and patient care; and licensing bodies regulate the practice of medicine. To this I add the caveat—*as taught*, implying that physicians practice within the scope of their formal training as equals within a horizontally integrated system.

In chapter 3, "Integrative health and loving care: The promise and the limit," Mark Pilisuk, PhD, discusses why social support is critical to health. He envisions a system in which the role and perspective of the healthcare professional and the patient shift to one in which the relationship of the professional is to a client who is no longer an ailing individual, but an imperfectly functioning set of relationships and resources. Likewise, in chapter 4, "Healing environments for integrative healthcare," Susan Frey[12] discusses the value of architectural designs (i.e., healing gardens) to enhance the therapeutic experience in institutional facilities such as group homes, critical care units, and birthing centers.

In chapter 5, "Integrative healthcare in hospitals," Wayne Ruga, PhD, and Annette Ridneour introduce four vertically integrated collaborative models: Vidarkliniken in Jarna, Sweden, Planetree in Derby, Connecticut, Scripps Center for Integrative Medicine in San Diego, California, and North Hawaii Community Hospital in Kamuela. In addition to high-tech allopathic care, these facilities offer combinations of movement therapies, meditation and mindfulness-based stress reduction, healing gardens, social support networks, spirituality, healing touch, architectural designs, nutrition, exercise, pain management, vegetarian cooking classes, acupuncture, biofeedback, hypnosis, music therapy, massage, community prayer, and family birthing rooms. North Hawaii Community Hospital offers vertically integrated care in naturopathic medicine, chiropractic, and clinical psychology.

In chapter 6, "Integrative healthcare in rehabilitation," Barry Nierenberg, PhD; Robert Glueckauf, PhD; and Scott Miller, MA, discuss the history of rehabilitative therapy, the International Classification of Functioning (World Health Organization [WHO], 2001), the use of transdisciplinary knowledge, and the value of tai chi, deep breathing, nutrition, and spirituality and prayer in rehabilitation.

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[12]Susan Frey lists the credentials PhD, ND, and RN. Frey is a graduate of Clayton College of Natural Health, which is an unaccredited correspondence school with no clinical residential training. The state of Massachusetts has a pending law for the practice of naturopathic medicine; however there is a state society. Frey also claims a certification in massage therapy, which is a licensed profession in the state of Massachusetts.

In chapter 7, "Integrative protocols: Integrating philosophy and practice in the real world," Marie DiCowden, PhD; Frank Maye;[13] Diane Batshaw Eisman, MD; and Eugene Eisman, MD, present their views on the integration of allopathic, CAM, and behavioral models. The Eismans discuss the need for funding evidence-based research, for physician being open to the religious beliefs of their patients, and the fear of the integrative practitioner that complementary medicine will be used in place of conventional care.

In the sections following, Maye includes a discussion of the histories of TCM, naturopathy, and homeopathy. Having formally studied naturopathic medicine, I find Maye's explanation of the electromagnetic functioning of the meridians and Five Element theory lacking, and his discourse on naturopathy fraught with inconsistencies; especially when he states, "many naturopathic physicians employ sophisticated electrically amplified voltage (EAV) and bioresonance equipment to aid in discovering the cause of conditions" (p. 129). Maye also misses the salient point that naturopathic medicine is not an alternative, but a traditional or whole medical system, with formal education that is different from a "naturopath" and a conventional physician practicing natural medicine. This same comment applies to Maye's discourse on homeopathy. A useful comment would have addressed homeopathic potencies with respect to their physical, emotional, spiritual, constitutional, acute, and chronic properties. A discussion of the role of integrative medicine from the viewpoint of behavioral or mind–body medicine, which followed, focused on the use of guided imagery, relaxation, and meditation to help patients reframe their beliefs concerning expectations of efficacy regarding drugs or medical procedures.

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[13]Frank Maye, director of alternative medicine at the Biscayne Institutes of Health and Living, lists the credentials DOM (Dr. of Oriental Medicine) and ND (naturopathic doctor). Maye has a Masters in Chinese philosophy and Oriental medicine from the Community School for Traditional Chinese Healthcare, Miami, FL, and is a graduate of the American Naturopathic Medical Institute, a correspondence school with no clinical residential training. In reviewing the statutes related to the use of the titles DOM or OMD, I found that this requires certification by National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM; accredited programs in the U.S. are found only at Bastyr University, Oregon College of Oriental Medicine, and Pacific College of Oriental Medicine). Maye did not graduate from a 4-year OMD program, and is neither board certified nor a member of a state or national professional group such as the Florida State Oriental Medical Association (FSOMA), NCCAOM, or American Association of Oriental Medicine. In reviewing the Florida state statutes relating to the use of the titles ND, NMD, naturopath, naturopathic doctor, and naturopathic physician, I found that they were protected terms to be used only by those licensed to practice in the state. As naturopathic medicine is a licensed and regulated profession in Florida, only licensed individuals may use these titles legally. Maye is not a member of the naturopathic physician's organization, the AANP.