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## BOOK REVIEW

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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).

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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

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,<sup>1</sup> 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<sup>2</sup> 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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<sup>1</sup>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.

<sup>2</sup>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 (Berdyayev, 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)<sup>3</sup> mind-body therapies, and define a role for humanistic psychology and the expressive and creative arts<sup>4</sup> 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.<sup>5</sup>

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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<sup>3</sup>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/whatiscam/>)

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

<sup>5</sup>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<sup>6</sup> 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,<sup>7</sup> 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*.<sup>8</sup> 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

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<sup>6</sup>Conventional refers to allopathic, osteopathic, dental, nursing, pharmacy, and allied health professionals.

<sup>7</sup>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).

<sup>8</sup>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 health-care system.