

# A Working Model of Health: Spirituality and Religiousness as Resources: Applications to Persons with Disability

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**ABSTRACT.** The author describes a model of health that incorporates the spiritual dimension of life, and articulates the relevancy of this model to those with disabilities. The model includes sociocultural, psychological, physical and spiritual aspects of life, around a central integrative core. The article enumerates some of the challenges faced by those with disabilities and contrasts the predominantly secular approach to life with examples of an approach which takes into account the spiritual dimension. Some spiritual and religious resources that may help meet these challenges, and help to integrate the life of the disabled person into a meaningful whole are described. [*Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: [getinfo@haworthpressinc.com](mailto:getinfo@haworthpressinc.com) <Website: <http://www.haworthpressinc.com>>*]

**KEYWORDS.** Disability, health, rehabilitation, spirituality

## ***A WORKING MODEL FOR THE INCLUSION OF THE SPIRITUAL/RELIGIOUS DIMENSION AS A PART OF HEALTH***

Health extends beyond the merely physical to take into account the entire picture of what it means to be human. The World Health Orga-

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nization (WHO) definition of health includes mental and social aspects,<sup>1</sup> and the WHO quality of life instrument includes the spiritual as well. This paper describes a model of health that incorporates the spiritual dimension of life as a part of health that needs to be taken into account. The model is also very interactive: it views health as a dynamic living process, not an isolated event in an isolated person.

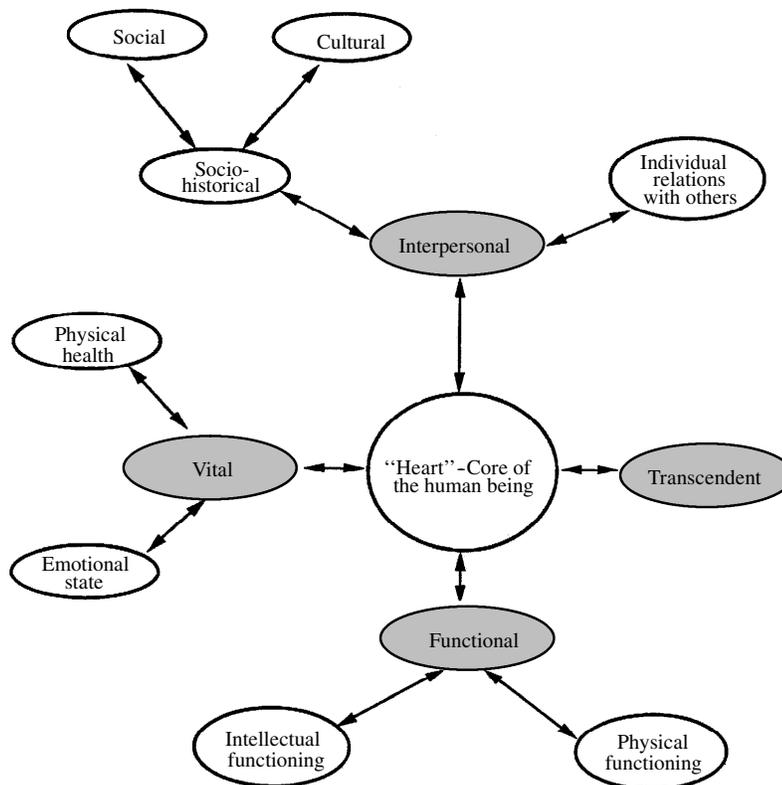
As human beings, we experience life as more than just functional units. There are many important things which define our lives. One of these is our *functional ability* to perform mental and physical tasks. But our *interpersonal relationships* are also important; we have effects on others and they on us. How do we relate to others on an individual basis? If as a child, we had parents who supported and sustained us emotionally and in other ways, that sense of security contributes to our sense of confidence and our ability to cope. Another component is our setting in society: What are the *social and cultural* forces that we must contend with and are shaped by? For example, we live in a society that highly prizes individualism. That societal value influences how we perceive our own value, especially when we require the help of others.

The structure of our physical bodies and our emotions strongly linked to our physiology create a *vital* part of life. For example, physiological changes can lead to physiological depression; depression can lead to lack of appetite which can decrease our energy and subsequent ability to function. Our religious traditions and relationship to the *transcendent* are also important parts of life for most, either implicitly or explicitly. We begin to touch this aspect when we examine the underlying motives for our actions and the meaning and values we ascribe to various features of life. The “why” of our lives tends to ultimately lean on something other than that which we can perceive with our five senses, be it defined as deeply felt moral conscience or relationship with God. An example of this reflected in behavior can be found in a report that 89% of Americans pray, according to a 1989 Gallup survey (Gallup and Jones 1989).

A key element of the model presented here is that it assumes that there is something in us beyond pure physical and psychological reactions—some basic center. In this presentation this will be referred to as the “Heart.” *The Oxford English Dictionary* defines heart as “the center, middle or innermost part of anything . . . the vital, essential part of anything.” The word “core” also comes from the Latin word for heart. The relationship of the “Heart” of a human being to all of the

other elements expressed above is summarized in Figure 1. The Heart as defined in this paper is at the center of the model; the four key dimensions of functional, vital, sociocultural and transcendent radiate from and into that center like spokes of a wheel, affecting the core and providing the means by which the person expresses himself in his surroundings. In creating the model presented in this paper, the core of the human being where integration happens is referred to as the “Heart.” It is a label for the place within that is not pure intellect or emotional sense or spiritual sense, or inspiration, or practical needs for functional or social interaction with the environment, but a place

FIGURE 1. A Working Model for Inclusion of the Spiritual Dimension



where these aspects can be sifted and integrated, and then flow out into the rest of our lives.

The basic components of this model are drawn from the work of Dr. Adrian van Kaam, a developmental psychologist who produced a phenomenological description of the interaction and integration of the various components of human life, with the aim of seeing these in relationship to the spiritual (van Kaam 1991). He described this by assigning specific words to clearly express certain concepts. In the model developed in this paper, some of the concept names have been changed to make the ideas more accessible, and the model tailored to address issues of health more clearly. Van Kaam developed his model in response to work with refugees during World War II. He saw a common thread running through the lives of Jews, Christians, and those who professed no religious attachment. The relationship with the “transcendent mystery of life” was important in many different individuals’ struggles with the sufferings of war and persecution. As he pursued graduate work in psychology he saw that despite religious differences among people there was a common influence of the “transcendent” dimension in life which had a role in addition to the psychological. He defines the “heart” as the affective dynamic center of the individual, having the most enduring and decisive effects on the form of that life (van Kaam 1989). Van Kaam’s approach broadens the view from the narrow one that life is a functional product of society, psychology, and physiology. This can give a more fully accurate picture of human life as we experience it, vibrant and uniquely human.

Some attempt at definition of terms might elaborate on how one might try to define “spiritual” aspects of life, and also include possible overlap with the term “religious.” There is, for most, an aspect of life that is transcendent-transcending the physical, emotional, functional and social aspects of life and giving additional meaning to much of what we do. For 95% of people living in the United States this is linked to a Judeo-Christian religious background and flows from that to some extent, even if the original doctrines have been subsequently rejected (Princeton Religion Research Center 1987). Relationship to God (or to the transcendent by some other name- “God” will be used in this paper to refer to this) forms an integral part of that aspect of our lives. One underlying feature of this approach is the assumption that there is more to life than that which we can see or fully understand. It is in living in the context of this “more than” that our spiritual lives

develop, and the capacities available to be used in coping are enlarged. The following definition of the spiritual by Prezioso was of particular interest:

Spirituality is a quality that belongs exclusively to the human animal. . . . It's the life energy, the restlessness, that calls us beyond "self" to concern for, and relationships with, others and to a relationship with the mysterious "other." Spirituality is our ability to stand outside of ourselves and consider the meaning of our actions, the complexity of our motives and the impact we have on the world around us. It is our capacity to experience passion for a cause, compassion for others and forgiveness of self. Spirituality is a process of becoming, not an achievement; a potential rather than a possession. . . . (1987)

The "religious" is tied more to doctrinal, denominational orientations and to external aspects such as church attendance. Someone could be outwardly religious, yet not have a strong relationship to the transcendent. The religious orientation can be motivated by social needs or superstition and can exist without the spiritual. However "spirituality" ideally underlies healthy religious attitudes. As referred to in this discussion, spirituality flows from our relationship with the transcendent, the "more than," and flows out into various dimensions of the human life. The manifestation of the spiritual varies greatly from one person to the next because the physical, emotional, functional and interpersonal circumstances are different for each person. But characteristics such as compassion, appreciation, and a healthy yet realistic sense of self, are often found in those for whom the spiritual is an important feature of their lives. The spiritual is usually rooted in a traditional religion and can definitely gain strength from additional resources which it provides.

In the following section, the emphasis will be on exploration of the elements of this model relevant to the role of spirituality and religiousness in the lives of those with disabilities. The concept of an integrative core, the "Heart," is very helpful in this respect. As human beings we are not wholly defined by our physical structures, intellectual abilities, social and cultural setting, or religious and spiritual experience. Even our emotions, which can sometimes seem to dominate the picture, are not the integrative core. This core lies deeper than all these things: if various elements are not functioning correctly, it can cause

distress and disruption, but the human being need not be destroyed, because he is operating out of this integrative core. He can define himself much more fully, taking all aspects into account. The Heart provides a place where various forces can be integrated into a whole which is healthy, despite the limitations of various dimensions.

This model provides a way of examining the whole person as referred to in the mission statement of the National Center for Medical Rehabilitation Research of the National Institutes of Health. The person with physical disability is a very good example of the fact that although many of the peripheral things in the model (social, functional, physical) may be disturbed in the extreme, there is a central essence that remains intact and that can provide a way to live beyond these limitations. And the integrative core, the "Heart," links the various dimensions: social/cultural, functional/intellectual, physical/emotional, and spiritual/transcendent, enabling this full reality to be fully incorporated into practical daily living.

Certain concepts in life involve a number of the component parts of the model simultaneously. For example, our relationships with others can involve the vital, both physical and emotional, the functional as in many work relationships, the interpersonal, and the transcendent when we relate to people in a spiritual context. An example of the effect of this transcendent dimension on relationships would be the expression of unconditional love for another, love not motivated by the positive benefits to oneself in the action but by something intangible and inspiring.

Another aspect of this model is that it emphasizes the reciprocal interaction between the person and his surroundings. "No man is an Island, intire of itselfe; every man is a peece of the Continent, a part of the maine; if a Clod be washed away by the Sea, Europe is the lesse, as well as if a Promontorie were, as well as if a Mannor of thy friends or of thy own were; any man's death diminishes me, because I am involved in Mankinde: And therefor never send to know for whom the bell tolls; it tolls for thee" (John Donne). We are influenced by our surroundings and we have effects on our surroundings. It is a dynamic living process. The way we cope with a disability influences those close to us and the way they respond to us. The wife whose husband becomes disabled can be profoundly influenced emotionally and practically. The emotional and functional responses of her husband in turn affect how she copes with the event. The quality of their relationship

in the process can profoundly influence the lives of both. We affect the form of each other. This model enables us to clearly see things in their complexity. Also, there exists the same interactive relationship between the whole individual and the transcendent—giving and receiving—dynamically alive. For example, the sense of sustaining presence that can come from religious and spiritual interaction can find itself being expressed as unconditional love in a community context, giving selflessly to those around us.

The interactive nature of the model extends to our physical state as well. Our physical state affects our core “Heart” profoundly, with repercussions on our intellectual views, and our relationship with the transcendent. When we are exhausted, we are less able to think clearly and can be less likely to engage in prayer, for example. On the other hand, occasional extreme pain or distress can temporarily heighten one’s conscious appreciation, both intellectually and emotionally. Viktor Frankl spoke, from experience, of extreme suffering as having the ability to assist in man’s search for meaning (Frankl 1985). Conversely, the body, with its constant demands, feelings and moods, can keep us from being able to see a bigger picture, constantly distracting us with neuromuscular signals.

Our functional intellectual ideas, or cognitions, can also have effects on our physical bodies. In medical clinical trials it is a recognized fact that expecting that one can do better can improve one’s outcome (Feinstein 1985). The importance of this is shown by the established need to “control” in all clinical trials by “blinding” patients, not informing them of which treatment they are assigned to. The evidence that high stress can be detrimental to physical health, affecting systems as diverse as immune, cardiovascular, hormonal and gastrointestinal, is being documented continually and is based on a model which is congruent with this approach (Cassileth and Drossman 1993; Cohen, Kessler and Underwood Gordon 1995). A stress response is secondary to the actual stressful events that occur. It is only when events are consciously or unconsciously interpreted by the person as stressful that they are transformed into emotional and physical distress. The role of the “Heart” as integrative core is congruent with this model. Stressful events are interpreted by the Heart in light of intellectual understanding and the effect of the transcendent on that evaluation, whether by inspiration or attribution of meaning to the experience. One result of this can be a “vital” response—emotional and physical.

Another example of this is that certain ways of interpreting the meaning of events can lead to depression. Depression can actually lead to a worse prognosis following a heart attack, as rehabilitation is impaired (Frasure-Smith, Lesperance and Talajic 1993).

The many parts of this model require integration and balance. Each part is important to the whole. If our functional intellect dominates our character, we can become cold, merciless, or isolated. If our emotions dominate we can become hysterical. If our physical selves dominate we can become excessively driven by our physical needs. Even if the driving feature is the spiritual, it needs balance too. "Spiritual excitement takes pathological forms whenever other interests are too few and the intellect too narrow" (James 1902).

Disability, by definition, affects one aspect of the vital part of life, the physical components, and this physical aspect of life also affects the way one interacts with other people and society as a whole—how one is responded to and responds. It has significant impact on the functional, practical aspects of life. Physical changes can affect emotions directly, through hormonal and autonomic nervous system changes, and more indirectly as the physical changes affect us in other ways. For example, the inability to engage in normal social activities may make a person more susceptible to depression. But the spiritual and religious can also have a direct positive effect on one's overall health. A recent study by Oxman and colleagues at Dartmouth found that finding a sense of strength and support in your religion was an independent positive predictor of survival, six months following cardiac surgery (Oxman, Freeman and Manheimer 1995). Religion and spirituality can also act in our physical bodies by providing an effective way of coping with stress, and can thus have a potential positive effect on a variety of organ systems. Maton, in his article on the stress buffering role of spiritual support, using both longitudinal and cross sectional studies showed that spiritual and religious factors, such as our relationship with the transcendent, can moderate stress (Maton 1989). Attending religious activities might provide social support and intellectual insight into one's situation through theology in addition to possible interaction with the transcendent. The hope and perspective provided by the spiritual aspect of life can often enable people to cope better with stress, even if they are unable to attend religious activities. An excellent quantitative and qualitative study looking at responses of 146 patients in an urban outpatient rehabilitation clinic looked at

self-ratings of health, and also explored religious and spiritual views of the patients. The data showed that the people with greater disability were more likely to have sought help from their spiritual or religious resources. There was a consistent theme of turning to religion in need, and one of the main ways that religion helped was by letting people “rise above” their problems (Idler 1995).

As we consider which interventions might help those with disabilities most, or what factors need to be taken into account as we examine the well-being of those with disabilities, we need to consider the various components of the human person and the many aspects of their problems. This model can be helpful in giving conceptual clarity to research in this area, simplifying complex interactions. And it is crucial to always keep in mind the vibrant interactive nature of the entire process which reflects the exciting mystery of life; one that we will never completely be able to articulate intellectually.

***APPLYING THE MODEL TO THE LIVES OF THE PERSON  
WITH DISABILITIES AND THEIR FAMILY:  
RELIGIOUS AND SPIRITUAL RESOURCES***

Although hospitalization and outpatient rehabilitation care can form an important part of the lives of those with disabilities, for most, the majority of life is lived apart from these settings. The rubber hits the road in the challenges of living. The mind grapples with questions of meaning. Interpersonal relationships are tested. The body is faced with its limits. Emotional and physical suffering clamor to be addressed. The person tries to adapt to and cope with the disability. There are many tools available to do this, too numerous to cover in this paper, but which include psychological coping skills and social support. But these tools are not always in such good shape, and even if they are, they are often insufficient to do the job. The spiritual and religious can be a crucial factor in this process.

As the potential positive contribution of the spiritual is presented in the following section, the issue of negative implications of specific beliefs on coping is also raised. The assumption in this paper is not that one religion is better than another in helping the ability to cope, but that a full, rich, alive spiritual commitment, frequently rooted in a traditional religious context, is more likely to lead to effective coping. The more negative influences can result from a lack of understanding

of the foundational truths of religious experience. The concept of the “spiritual” tries to shed the more external aspects of religious experience to reflect the deeper characteristics of soul and spirit.

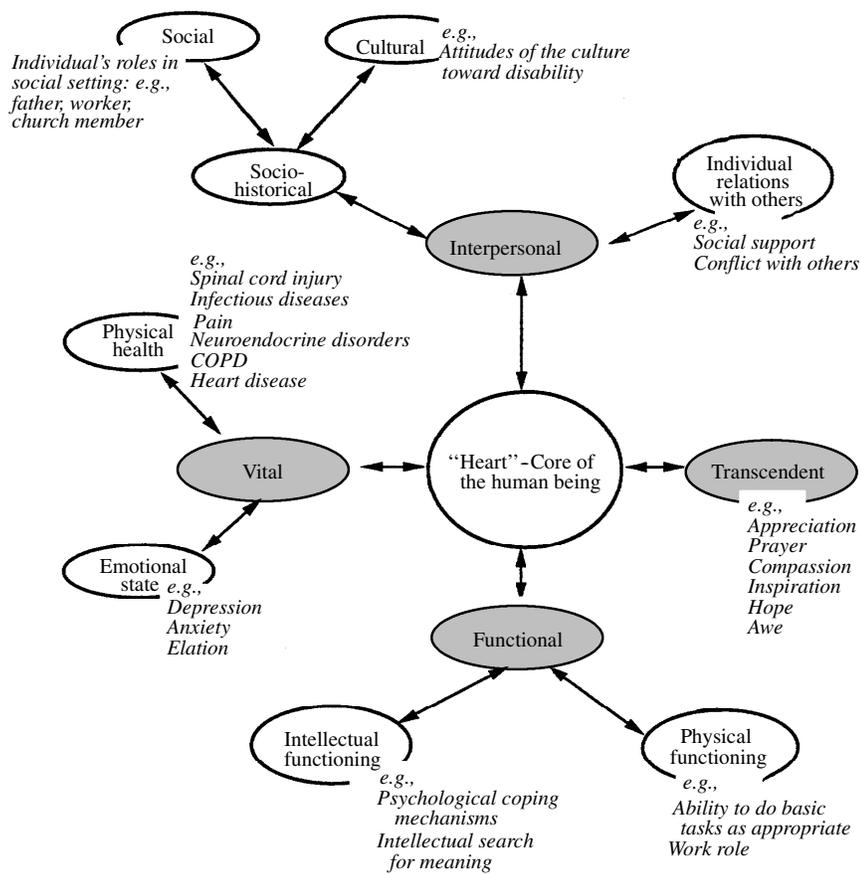
### *Challenges*

In giving an overview of the role of the spiritual and religious in dealing with disability, the approach taken here will be to enumerate some of the challenges faced by those with disabilities and contrast the predominant secular approach with examples of some spiritual ones which can be more helpful. Throughout this section, it may be useful to refer to Figure 2, which shows how some of these factors might fit into the “Heart” working model. It is important to emphasize in this overview the spectrum of individual differences. Comments and issues raised will address common themes. But for each individual person, the religious heritage, personality, type and degree of disability, and social setting, among other issues, affect each life in a unique way. For each person, the individual components that fit into the “Heart” model are distinctly different. It is hoped, however, that the issues raised have relevance for this wide spectrum.

*Functionalism.* The functional world defines people in terms of how effectively they perform functions: in other words, as “human doings” rather than human beings. The spiritual approach tends to view the functional aspect as just one part of life, with issues such as root motivations and attitudes such as appreciation, awe and compassion being ultimately more important. The disabled person is at a disadvantage in the world constrained by functional evaluations. When the physical self is by definition below par, a person is limited in some areas of functioning. He may compensate by excellence in other areas, but there are still disadvantages compared with others. The additional perspective introduced by the role of the transcendent can be very helpful. One can see that his value truly transcends the functional. Jean Vanier has articulated this attitude in his approach to people with mental disabilities (Vanier 1985). He came from a background which highly valued intellectual prowess, and yet when he encountered those with mental disabilities he was confronted with the “more than.” He saw a precious nature in those with mental handicaps. He saw the joy and love that people with mental disabilities could share with others around them. He saw that his intellectual and functional criteria were insufficient to evaluate the worth of people. As

a result of these insights, which emerged from a deep faith in God, he began to establish communities for those with mental disability based on mutual respect for the unique value of each person. The L'Arche communities have become models for community living in these situations. It is easier to maintain this attitude of fundamental respect for a person regardless of his ability to function mentally or physically when buoyed by a spiritual attitude towards all of life. This also

FIGURE 2. A Working Model for Inclusion of the Spiritual Dimension: Some Examples



applies to our attitudes towards ourselves—it takes courage to value ourselves for the attitudes of our hearts, rather than our achievements. But it is precisely this more spiritual perspective that helps us to cope with the functional limitations presented by physical disabilities.

*Unfairness.* One place where spirituality can really be of major assistance in coping with disability is the issue of unfairness. The question “why me?” represents some part of this issue of unfairness. Society tends to infer that people get what they deserve, and this also clouds the issue. The spiritual and religious can be important tools to address this perspective. In a spiritual context of the “more than,” many things that are very important are not seen or understood. One sees just a few pieces of the puzzle—the big picture is not yet visible. This can be very helpful in coping with the question “why me?” and in dealing with the unfairness of being disabled. Perspectives such as the following quotation from Evelyn Underhill, an Oxford theologian at the turn of the century, can be helpful:

. . . with this widening of the horizon, our personal ups and downs, desires, cravings, efforts, are seen in scale; as small and transitory spiritual facts, within a vast, abiding spiritual world, and lit by a steady spiritual light. And at once a new coherence comes into our existence, a new tranquillity and release. Like a chalet in the Alps, that homely existence gains atmosphere, dignity, significance from the greatness of the sky above it and the background of the everlasting hills . . . (1993)

Some theological explanations can also help develop a rational understanding of this issue. One example is the perspective that challenges are positive in that they help us grow in ways that are eternally important. Trieschmann comments in her book on spinal cord injury rehabilitation on a group of studies of long-term adjustment to spinal cord injury. For some, the experience of the disability had made them stronger, more confident and more patient, and some also had more positive feelings about themselves than before their accident (Trieschmann 1988). But even this does not include other qualities that often come under the headings of character and wisdom, such as trust, endurance, tolerance, and compassion. These are very important if one is including the transcendent as a component of the human being.

It must also be stated in this context that certain interpretations of religious perspectives can be damaging to coping abilities. Pargament

and Hahn (1986) have collected data that some people can view disability as punishment meted out by God and this can obstruct coping. Other ways of relating to God do not put this negative interpretation on events. One's image of God is crucial in this regard.

In the final assessment, it can clearly be seen that life is not fair in the obvious sense, but that beyond the obvious there is hope in a greater order. A spiritual attitude has a potential significant contribution and must be taken into account as we think of the lives of those who are disabled.

*Self-Sufficiency.* One implicit dominant belief of our culture is that anyone can do anything if they just try hard enough: if you are having difficulties, it is either because you have made a mistake or you are not trying hard enough. This is clearly not the case for disabled persons. The energy required merely to do the basic daily tasks can be a significant drain on the disabled person's resources, although the degree varies from disease to disease. It is also crucial to remember in this context the "Heart" model of the person. One of the factors that is important in shaping the life of each person is the interpersonal: interactions with individuals and society and culture.

A powerful way of coping is to be the recipient of social support. Studies have shown that social support can have a powerful positive effect on one's physical and mental health (Spiegel, Bloom and Yalom 1981, Berkman, Leo-Summers and Horwitz 1992). The drive for self-sufficiency pervades our culture. This is another feature of life that can be a constant difficulty for those who are disabled. Somehow, society infers that doing it by yourself is better than doing something with help. The spiritual perspective at its best emphasizes compassion and doing good for others. It acknowledges an ultimate importance in human relationships. It reinforces the good aspects of this kind of coping, encouraging others to provide support for the one who needs it, thereby entering into a rich relationship in the process. The downside of the religious approach can be that one does not encourage the value of receiving care and concern and instead creates guilt. It is often forgotten that the helper is also benefiting by the interaction, returning to the interactive nature of the "Heart" model. We form each other as we interact. Despite the negative possibilities, the positive contributions of religious perspectives toward the solution of this problem are significant and cannot be underestimated. The social structures provided by religious institutions can at their best reflect

and express fully the deep care and concern and compassion which we all need.

In addition to support from other people, there is the possibility of direct support from God. Gerald May elaborated on this approach in his book, *Addiction and Grace* (May 1988). He emphasized that it is when one really sees he can do nothing and that he is at the bottom of his own resources, that there is a point of natural openness to God's help. For some, this means that internal spiritual forces can enable and strengthen. Many religions also believe that supernatural assistance for physical strength and healing can be given by God. One clinical trial has explored this issue and has provided some preliminary evidence for this (Byrd 1988). The potentially detrimental side of this belief is the negative religious interpretation that, if the requested improvement does not occur, then that person must have insufficient faith. When present, this interpretation is usually placed on the situation by others in the religious community. It can result in guilt and damage to the ability to cope on the part of the disabled person.

Another issue that is often discussed in the behavioral medicine and psychology literature is the importance of a sense of control in one's life. This is usually thought of as "internal," "I control my own destiny," vs. "external," "other people or chance events control my destiny." The internal locus is usually assumed to be superior, leading to better mental and even sometimes physical health (Cohen et al. 1995). The "Heart" model enables us to look at this concept of control in a different way. What kind of "locus of control" would include belief that God would actively intervene, either by strengthening and enabling from within or with other direct help in response to prayer? This is often part of coping, particularly in difficult circumstances. There has been some specific discussion in the literature about the use of prayer as a coping mechanism (Saudia et al. 1991). The coping paradigm might be greatly improved by using the "Heart" model as a way to include the transcendent dimension. Including the transcendent in our picture of who controls life can be an important part of the whole picture. The concept that the transcendent might empower those who do not seem to be able to control their situation could be very helpful. The belief that through situations and other people, God cares and is in control, may provide one with a very strong source of support.

*Time.* Another area where the spiritual can have a significant balancing influence on one's way of coping concerns how one views

time. Rushing and efficiency is prized by our dominant culture. The focus is on the future—getting there as quickly as one can. The present is only a tool to get to the future. The present is only a position on a timeline. The spiritual perspective allows space for experiencing the present moment fully and acting fully in the present, not for its utility for the future but in and of itself. The eternal perspective, the place in the as-yet-unknown big picture, can preserve one from the “rat race.” For the disabled person this perspective can facilitate coping. Due to physical limitations it is frequently impossible to keep up with the pace of things. This can be very frustrating. The eternal perspective allows one to enjoy moments of life and to value “inefficient” actions such as listening quietly to others, reveling in the beauty of nature, expressing care and concern. By welcoming this perspective, the disabled person can have an enriched life and often enrich the lives of others. And ironically, this approach can often be more efficient in the long run as the bigger picture emerges.

*Suffering.* The dominant culture views comfort and pleasure as crucial to happiness. Yet the question “What is real happiness?” has an answer which lies beyond comfort and pleasure. The disabled person has to deal with the issue of suffering, discomfort, and displeasure very acutely. With the spiritual approach can come an acceptance of limitations as part of the riverbed that holds the river of individual life on its course. This is helped by the transcendent perspective that defines life as “more than” function and performance. The assumption that much of importance cannot be seen clearly can put suffering into perspective. For example: John Carmody is a theologian who is suffering from cancer of the bone marrow. In a recent article he shares about his experiences:

Apart from God, I find no meaning able to bear a life’s weight. This proposition is both ontological and mystical. Nothing in my experience makes a center that holds. . . . Without a God who works in my experience but also escapes it and transcends it. . . . The grass withers. The flowers fade. All of our bones dry up and fracture sooner or later. The only bedrock I have found for rest is the stunning fact (unavoidable empirical reality) that there is always more—outside of me, within me, for my body, for my mind, historically, socially. (1994)

### ***Spiritual Resources***

Given some of these problems that those with disabilities face, what specific “spiritual tools” and resources are available that might help to better cope with these problems and encourage better health in the whole sense? How might one go about buoying up the spiritual approach to some of the issues raised in the previous section? All that can be done in the space of this paper is to indicate a range of possible tools available for exploration. These are just a sampling.

*Spiritual Friendship.* To seek the presence of others who are accepting, honest, empathetic, compassionate and understanding is one way to encourage the spiritual dimension. We often encounter these people in our daily lives, and when we do, it can be most welcome. However, there are specific professionals who can also be very helpful. Therapists and medical professionals with a sympathy for and openness to the spiritual dimension are one possibility. Pastors and rabbis can also have an obvious role. There is also a specific stream that has had a resurgence in modern times among Christians, which has strong roots in the monastic communities of the middle ages. That is the role of “spiritual friend,” sometimes referred to as a spiritual director (Jones 1982). This is a person who tries to listen openly to the daily struggles of another with particular attention to the spiritual dimension and implications of thoughts, feelings, and actions. Sharing with someone in this intentional way can be very helpful in clarifying ones own approach.

*Community.* Another possible source of encouraging the spiritual dimension is by relating fully within the community in which you find yourself. Drawing from religious communities, such as church and synagogue resources and structures, and giving of our own richness to those communities is one way of doing this. Religious communities can have access to a variety of useful resources as well. One can also create community where very little exists, and this community can be a vehicle for communal spiritual life.

*Standing in Life as It Is.* Developing certain attitudes and mental approaches can also be of help. Self-acceptance and standing in life as it is are ways of viewing life that can be conducive to the spiritual. A spiritual approach that is not concretely linked to events, feelings, and thoughts as they truly are can be problematic (Zelevnik 1975). Buddhists have an approach called “mindfulness” which can be helpful in standing in the present moment, rather than living in the past or future,

and consider it a form of meditation. This can also be helpful. Noticing that we are angry, and accepting this as what is without judgment, is one example. “Smelling the flowers” as we are moving through the functional aspects of life is another.

*Writing.* Reflection also can help us to obtain insight into ourselves and our situations. Keeping a journal or in other ways writing about daily events and past events is one active way of reflection. Ira Progoff (1992) has taken the tool of writing and created a specific method of using writing as a tool for integrating the spiritual dimension of life into our overall development. Writing can help to put events and feelings in a greater perspective and to gain a greater awareness of them. There is some evidence that writing about traumatic events can have an integrative effect on the self, and even a positive effect on the immune system (Pennebaker 1993).

*Reading.* Reading can be educational, inspirational, and devotional. Traditional religious scriptures are an obvious start, but in addition to those are books and articles written by those sharing their own spiritual insights and experience. There are different ways of reading spiritual material, ranging from the purely intellectual, to reading at a level of listening that allows the words to speak more directly to the heart (Smith 1989).

*Art.* Expressing oneself artistically can also be a way of encouraging the spiritual dimension (L’Engle 1980). Painting, movement, music, can all encourage the expression of the “Heart” in ways that are not purely functional. There is a directness about art that can, at its best, bypass the unimportant. Artistic inspiration can be a way of attending to the transcendent dimension of life and allowing that to flow into activity.

*Prayer.* Prayer is an obvious spiritual resource. Prayer can happen on a conversational level, expressing feelings, issues and concerns in an environment of trust, with the expectation of inspiration from the transcendent. Prayer can also be more contemplative or meditative, “intense attention to the sustaining presence of the holy” (Zelevnik 1975). There has been a recent resurgence of interest in contemplative prayer (Keating 1986). Carmody (1994), in his description of dealing with daily suffering with cancer, states that contemplating the “more than” nourishes his spirit as nothing else can.

*Nature.* Seeking out natural environments is a way of connecting to the bigger picture. For those who are alienated from religious tradi-

tions in particular, this can be a way of touching creation—and the qualities of beauty, mystery, awe, and gratefulness—and connecting with that which is transcendent.

*Humor.* Humor and playfulness are both important as we try to keep perspective. There is a timeless quality in humor which can enable us to rise above the pressures and functional orientations of secular life. In cultivating humor we can allow ourselves to delightfully appreciate the incongruities of daily life, and in doing so encourage perspective. From a spiritual perspective, humor can rescue the human spirit from a sense of despair (Pasquali 1991).

These resources have potential usefulness not only for those with disabilities, but also for those in their family and others close to them. As the “Heart” model emphasizes, our lives are interconnected. That interpersonal aspect of life is a crucial one. We are affected by those around us and they have effects on us. Resources for people close to those with disabilities are also important to consider.

There is always the temptation to apply a set of interventions that will effectively address everyone’s needs. However helpful this may be in principle, it is rarely the best solution, even in clinical medicine. Surgery needs to take into account individual differences, even though our physical selves have many more similarities to each other than our hearts and minds. The young person with spinal cord injury has different needs and orientations and problems from the aging person with chronic obstructive lung disease. The person disabled from birth has a different perspective from someone with a cancer occurring in mid-life. Different cultures have different dominant perspectives.

The secular attitude as expressed in this paper reflects white middle-class America, the culture which seems to dominate the public attitude as reflected in the media and other structural aspects of American life. Other cultures may be more supportive for the individual with disabilities or provide additional problems. Certain tools may be especially appropriate in a particular social or cultural setting.

The religious background of a person is especially important when we try to address the kinds of spiritual approaches and tools that might be most useful. And the relationship of a person to his or her particular traditional religious approach is also to be considered. Crisis causes a rethinking of the spiritual. In the best circumstances a deeper, more authentic spiritual attitude emerges. It is an attitude better able to cope with the complexities of life and able to provide the additional strength

necessary to cope with difficulties effectively. Initial negative reactions to religious traditions may be necessary for some to shed the more superficial and even destructive thinking. For some, this is not necessary and they can immediately draw upon traditional religious structures. Changes in specific religious orientation may also emerge for some.

Psychological state and personality vary so much from one person to another. The kind of spiritual tools appropriate for a natural optimist will vary from those for someone experiencing depression. Although personality may remain constant, psychological state can vary extremely over the course of life for a disabled person. The need for change as one grows and adapts is important to take into account. There need to be a variety of tools and resources made available to the person with a disability.

The approaches and problems presented above have general applicability. However, each person is unique. What is most helpful for many could have no applicability to some. In returning to the "Heart" model, the complexity of each individual, especially when taking into account their social, cultural, and religious background, is glorious. The goal is to facilitate the integration of all the various aspects of life into a meaningful whole, able to express fully the heart of the human being within the concrete situations of life.

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