The Aesthetics of Interpersonal Attunement in Spiritual Care

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This article explores how storytelling plays an integral role in interpersonal attunement, attachment, and spiritual caregiving. An interpersonal style of attuning to the experiences of others constitutes an ethical aesthetic of resonant harmonizing between the bodies, nervous systems, and minds of caregivers and patients. Neurobiological research has provided empirical scaffolding to rationally understand how attuned relations regulate the nervous systems of the relating persons. Compassionate caregiving in clinical chaplaincy practices relies on the cultivation of self-regulation capacities through meditation practices on the part of caregivers. Compassionate caregivers then use their emotional equilibrium and empathic insights to open an interpersonal space for receiving the stories of patients, families, and other caregivers in clinical settings. Self-regulation and self-transcendence depend on the empathic understanding between persons and social groups that counteract the harms endemic to many late modern social institutions in which systemic violence often takes place. This article concludes that attuned spiritual caregiving is an appropriate social response to complex trauma and social suffering in the late modern context.

Some say the world will end in fire,
Some say in ice.
From what I've tasted of desire,
I hold with those who favor fire.
But if it had to perish twice,
I think I know enough of hate,
To say that for destruction ice
Is also great
And would suffice.
—Robert Frost

As early as I can remember, I loved the play of images, emotions, and thoughts in poetry and storytelling. As a young man in high school and college, reading and discussing literature so appealed to me that I often neglected my other studies so that I could read books that recounted imaginary events, people, and places. As I matured into a scholar and spiritual caregiver, I found myself returning again and again to the power of stories for reasons I could not always explicitly relate to others. I studied the anthropology of storytelling intensely at seminary. In my theological education and in my doctoral program, I learned to deconstruct narrative structures and to show narrative contingency. I impressed myself with my ability to suspect the untruths or untold truths that narratives masked, seeing the telling of narratives as but one more game of truth in an array of knowledge construction. All along, a strong gut sense remained inside that stories have meanings beyond what we learn from their contents, deconstructions, or social functions.

I intuited that stories grow as social organisms that bind together and break apart communities, worlds, and worldviews. Recent social and political developments, of the tragic and noble variety, have not convinced me otherwise. Responsible and attuned caregiving requires I resonate with my internal world as the basis for understanding others. So, I begin with this autobiographical aside in order to frame an argument about the value and limitations of stories in the practice of spiritual care. Spiritual care is a discipline that informs the practice of hospital chaplaincy. It combines religious practices with psychotherapy, attempting to make meaning out of illness experiences. Hospital chaplains attend to the needs for comfort, companionship, and meaning-making of patients, families, and caregivers who confront health crises. Spiritual care has captivated my scholarly and practical attention for nearly a decade because I see in it a dignified effort to humanize contemporary medical institutions.

In this article, I will make an argument for the value of deeply listening to stories, and about the beautiful reciprocity that emerges between a listener and teller. I will warn against the fearful symmetry that prevails when threat characterizes human interaction. I will describe how stories can integrate the experience of trauma survivors after calm and peace return to life. The positions I articulate here are informed by my original love of narratives put into dialogue with threads of scholarship found in the disciplines of interpersonal neurobiology, attachment theory, and integrative and attuned storytelling. Looking at storytelling from the interaction of these fields of study leads me to an appreciation for the neurobiological prerequisites for empathically sharing stories and the value of storytelling as a social mode of integrative healing. My broad point is that human interaction exhibits an ethical aesthetics of mutuality, which can take sublime and terrible forms depending on the state of the

bodies and minds that encounter each other.

Why is compassionate care so necessary for healing?

Besides the fact that compassionate care viscerally feels like the right response to mobilize when tending to persons contending with an illness, it activates bodily healing. Isolated persons in a lonely hospital room suffer intensely from the bodily consequences of being removed from the social context in which they feel physical, social, and emotional support. Consider the following scene. A woman named Clara wakes up in a dark room on a bed with stiff linens, clothed in a rough gown, with her torso raised slightly above her legs. She hears the slow and steady beat of a heart monitor. The sounds of people hurrying to and fro in the hallway just outside her room slip below the bottom of her door. She is not entirely sure where she is at first.

Day breaks shortly thereafter and a nurse comes into what Clara realizes is her hospital room. The nurse asks Clara questions to see if she knows her own identity. Clara does remember her name, age, work, and family. She is unsure of the date, and some of the details of the last few days are unclear to her. She remembers a searing pain in her left arm that she felt at work earlier. "That must have been yesterday," Clara thinks to herself. Her nurse comes and goes every hour, makes eye contact, talks to her for a few minutes, and then spends her time charting on the room's laptop. The nurse's eyes are kind but the moment of connection is brief. Clara feels scared.

She also feels confused, and by the end of the day she is wondering where her family is. She starts to feel an uneasy tightness in her lower abdomen. She starts to want to talk with someone to pass the time. She grows ever more worried about what happened and what that means to her future. The nurse said that Clara suffered from a heart attack. Clara is shocked and wonders what changes she will need to make in her life to avoid any future cardiac events.

Neurophysiological and immune system research suggests that an overly active sympathetic nervous system removes the body from the restorative state necessary for healing (Porges, 2017; Van der Kolk, 2015). The sympathetic nervous system is associated with arousal, anxiety, fear, stress hormone release, and fight or flight states. Its counterpart is the parasympathetic nervous system, which dampens arousal states. Human beings most readily activate parasympathetic response through social engagement, including storytelling, grooming, singing, and gentle physical touch. Spiritual caregivers provide the kind of receptive presence that dampens physiological arousal, helping patients relax through social engagement and talk. The need for spaces of open and trusting communication is not confined merely to medical institutions. Imagine the social isolation in prison systems, and one can intuitively see the validity of the argument for more and better trained chaplains in many late modern institutions to assuage human suffering.

The application of chaplaincy craft applies in social institutions and movements beyond the traditional places where chaplaincy has emerged. Chaplaincy serves the needs of persons facing questions of meaning and integrity outside of the military, prison, and hospital settings in which it historically arose. Chaplain Jinji Willingham, a graduate of Upaya Zen Center's chaplaincy training program, suggested chaplaincy will become the front line spiritual therapy in the next generation. Working with the notion of interpersonal repair, Willingham argues that chaplains counteract the primary wounding that takes place so often in social contexts when attuned relationships are absent or strained.[1] Chaplains provide a body-nervous system-mind capable of attuning. This means chaplains can mirror the emotions they see in others while adding compassionate response in such a way as to provide means for interpersonal healing that quenches negative reciprocity. The leadership of Upaya, one of the foremost training programs for Zen Buddhist chaplains in the US, have also provided the social scientific and neurobiological scaffolding that supports claims about contemplative chaplains' effectiveness in interpersonal neurobiological terms. Chaplains and other medical practitioners who periodically gather for intensive retreats at Upaya at the foot of the Sangre de Christo Mountains on the north side of Santa Fe endeavor to cultivate a sense of self that acts compassionately when confronted with suffering.

What does adaptive interpersonal symmetry look like in compassionate caregiving?

The practice of a helping profession like chaplaincy, clinical psychology, or counseling pivots on the exchange of stories. Engaging the social system necessary for such an exchange depends on all the parties involved achieving cognitive and emotional equilibrium. We can see this interpersonal dynamic at work in the ways in which caregivers reflect on how they, in relationship with patients, co-regulated the affective energies that all parties perceive and manage in clinical caregiving encounters. Co-regulation means that two or more bodies and extended nervous systems become partners in monitoring and modifying energetic flows in the context of relationship. One clinical chaplain describes in a particularly salient way how the process of compassionate listening requires properly attuning to herself. Naomi Saks is a Buddhist chaplain who works at the University of California San Francisco teaching hospital. Saks describes her ability to pay attention to stories she hears patients relate about their experience as a skillful awareness that resides in her body. Drawing on her training at Spirit Rock, a Northern Californian Buddhist community, Saks calls this intention to "soften"

[1] Willingham, Jinji: Personal Interview, May 5, 2018

herself to the moment and what happens in it "love."[2] When she roots in her own bodily experience and softens to what she finds, Saks provides herself with the means by which to attune to the presence of the patients, families, and other staff members she serves. She feels them inside her own bodily awareness.

When she is present to the full array of sensation, cognition, and emotion activated in her body and mind, she can be present to the sensation, cognition, and emotion she intuits in the bodies and minds of others. Saks practices a form of open awareness meditation practice each day. Her style of contemplative practice moves beyond any confineable location because she has internalized the capacity to be present no matter the circumstances of distress and hardship she finds within or without. She has cultivated this stance toward experience to such a degree that it has become intrinsic to her body, nervous system, and mind. It has become a character trait, and not just a temporary state of mind. "In my being," she continues, "I am present to what is arising moment by moment. I can feel that person I am visiting in a hospital room in my body-mind in the moment I am there with them if I am attentive."[3] Saks claims that when the patient's presence is available to her in her mind-body, she can better serve the patient because she can feel them and intuit their inner world. In her understanding of her practice, this awareness of the patients' experience in her sense of her own interior life is the index to point patients toward "being and allowing their experience to happen."[4] As Saks attunes to herself, she opens her awareness up to attune to others in her perception of the interpersonal field of being.[5] Exteroception—perception of the external sensory world—and interoception—perception of the inner visceral state—are intimately connected in her experience. That is, the identity of caregiver and patient can only emerge in the in-between spaces of relationship.

In this way, stories come to life in the bodily presence of the spiritual caregiver, which is like a theater screen displayed with the stories, thoughts, and affects of the people who talk with her. Her inner world resonates with the other's thoughts, feelings, and sensations. Saks goes on to offer her own observation about how early childhood experience makes accessing awareness of bodily states, sensations, and emotions difficult for many people in late modern US society. She proposes that our society makes experiencing emotions related to fear responses—anger, fear, hatred, contraction—unpalatable and unmentionable in everyday conversation. She then remarks, "I am not teaching people I visit anything that is beyond them or new, but I am helping them find the truth. I am helping them find a way to come home."[6] By finding a receptive caregiver, persons who are confronting the hardships of illness may have the ability to connect with themselves at a deeper level. They may be able to integrate more of their experiences.

In medical anthropologist Kleinman (1988)'s language they discover together "the moral lesson that illness teaches" (Kleinman, 1988). Suffering is ubiquitous, but it does not have the final say in what meaning human communities living in solidarity find in its face. In a reciprocal way, chaplains and patients care for and tend to each other. They can rebalance each other and provide each other with a pathway to self-transcendence. The aesthetic symmetry of care draws together two or more bodies and minds into one social organism that transcends any one member alone. Patients and chaplains are reciprocal caregivers that become one body entwined in the compassionate care of embodied awareness for the pain and suffering of imperiled or damaged human tissue in either organism.

The moral lesson of illness insists that pain and suffering are the inevitable precursors to self-transformation. Self-transformation necessarily entails some degree of self-transcendence. In this sense coming home means finding a way to recover knowledge of one's own body and at the same time to extend beyond one's bodily limits. Illness invites a return to the body as the primordial location of human dwelling,[7] while also showing how to cross over into another domain of experience unlimited by the body. In the same instant as one knows one's interoceptive experience, one is shown a passage for crossing over beyond the limits of one's body. Serving another as a guide home also gives the servant-guide the reciprocal gift of knowing the way home. "I am

[2]Saks, Naomi. Personal Interview, February 28, 2018

[3]Saks, Naomi. Personal Interview, February 28, 2018

[4]Saks, Naomi. Personal Interview, February 28, 2018

[5]The "intersubjective field of being" was a phrase repeatedly used by Fleet Maull in a training on compassion and wisdom he conducted from August 8, 2018 to August 11, 2018 at Upaya Zen Center. It originates with Maull's deep engagement with Daniel Siegel's work. That being said, numerous anthropological authors speak of the field of intersubjective relations including Fabian (2014), Kleinman (1988, 2007) and Jackson (2002). One brief quote from Kleinman (1988) points to how an emphasis on intersubjective experience leads to greater attention to the experience of suffering in medicine: "Ethnography, biography, history, and psychotherapy—these are the appropriate research methods to create knowledge about the personal world of suffering. These enable us to grasp, behind the simple sounds of bodily pain and psychiatric symptoms, the complex inner language of hurt, desperation, and moral pain (and also triumph) of living an illness" (Kleinman, 1988).

[6]Saks, Naomi. Personal Interview, February 28, 2018

[7]See Tweed (2009). Tweed (2009) insists on the religious activity associated with dwelling. Defining his usage of the term, he writes: "Dwelling, as I use the term, involves three overlapping processes: mapping, building, and inhabiting. It refers to the confluence of organic-cultural flows that allows devotees to map, build, and inhabit worlds. It is homemaking. In other words, as clusters of dwelling practices, religions orient individuals and groups in time and space, transform the natural environment, and allow devotees to inhabit the worlds they construct" (Tweed, 2009).

helping them, and I am helping myself, to come home and to soften when I am reactive and scared, when they are reactive and scared."[8] In providing orientation to a patient looking for a route back to her dwelling in the body, the clinical chaplain is gathering maps to orient her own homecoming.

Spiritual caregiving practices that find their ground in contemplation hinge on the social and emotional resonance between and within human beings. This means that assisting in the repair of another's relationship with herself or the imprint of her traumatic experience in her body also heals the chaplain providing the assistance. Saks's caregiving mode suggests that in doing mindfulness practice, the chaplain simultaneously improves her relationships with external actors—interpersonal attunement— and with herself internally—internal attunement (Siegel, 2011). She befriends herself, so that she can befriend others. Being a friend to herself and others also means accepting what she does not like.

What kind of body does the social engagement mediated through storytelling assume? What kind of body is capable of resonating with the heart of stories?

Taking care in stories, as Naomi Saks does rather skillfully, teaches a way to be in attuned relationship with others. It draws on all the learning that human beings discover when they take the time to gain an awareness of the complicated, beautiful, and fraught nature of intersubjective experience. Stories powerfully indicate the health of their narrators because they perform a type of healing that draws together the fragments of memory that traumatic events imprint in the body. These traumatic imprints tend to dissociate body and mind. Indeed "the body keeps the score," as the research of trauma theorist and psychiatrist Van der Kolk (2015) recently asserted so forcefully.[9]. The body keeps track of all the slings and arrows one suffers, even when the mind ignores or neglects them. Van der Kolk (2015)'s perspective resonates with those of anthropologists like Kleinman (2000) and Jackson (2002) on how social and interpersonal violence inflicts somatic wounds that alter human experience in deleterious ways. Talking about traumatic events does enable survivors to reintegrate their experiences but complex trauma poses problems to integration and healing that stories alone cannot solve.

Solving these problems essential for our time, a time when nationalist tribalism threatens to plunge our cities, states, and nation into a state of social and political disintegration. We need healing in interpersonal relationships but also in social institutions. We need a cadre of well-trained spiritual caregivers who embody the bodhisattva, that is never disparaging, unswerving, positive regard for all sentient beings. This kind of positive regard, practiced by the likes of Martin Luther King Jr. or Mahatma Gandhi or Jesus Christ or Shakyamuni Buddha, refuses to hate. As the Lotus Sutra narrates, Upaya's Joshin Byrnes reminds us, the bodhisattva's constant reply to all is: "I love you" (Byrnes & Quennell, 2019). As another famous bodhisattva expressed it so succinctly: "Those who will falsely accuse me, and others who will do me harm, and others still who will degrade me, may they all share in Awakening." [10] Limitless positive regard for others is the bedrock for attuned relationships. It is a boundless abode that is deeper and more loving than stories or any other artifact of worded techniques.

A social context in which we trade stories without limiting who gets to tell them, without privileging certain types of stories, requires the development of certain neurophysiological states. One of the most exciting elements of practicing a helping profession in the contemporary moment is the explosion of data and theories published in the last thirty years that objectively explore the interior of human experience with greater nuance and clarity. For example, the last three decades have witnessed an intensification of the search to link subjective experiences of the mind in relation to maps of activated neurological correlates. The studies on the nature of nervous system correlates to human consciousness and experience are so diverse that it is rather hard to characterize their import in one or two paradigmatic shifts.

For my purposes here, I will point to one particular paradigm shift that places greater awareness on the nature of bottom-up processing. Neuroscientist and Zen practitioner Austin James (2010) describes bottom-up processing as the stance of open awareness that meditators take when they activate temporal-occipital lobe pathways of attention. In this form of open monitoring meditation,[11] which is common to all schools of meditative practice in Buddhism, bare awareness is intuitive, insightful, and choiceless.[12] It foregrounds the experience of others. Social scientists and philosophers

[8] Saks, Naomi. Personal Interview, February 28, 2018

[9] Van der Kolk (2015), especially 89-106

[10] Śāntideva (1995), 21. Śāntideva wrote these verses in North India sometime between 685 and 763 CE.

[11] See Vago and David (2012), 13.

[12] Austin James (2010) describes bare awareness as the mode of consciousness that corresponds to a link between the temporal lobe, occipital lobe, and fusiform gyrus as they connect to the right prefrontal cortex structures associated with attention. Bare awareness focuses on the experiences of others in the surrounding environment. It enables a meditator to decenter. To achieve a state of unification with the outside world also requires dampening of the thalamus through GABA receptors of the dorsal thalamus, which quiets the limbic drives by closing the gate between the neocortex and the limbic system (amygdala, hippocampus, hypothalamus, and their associated supporting structures). GABA is the inhibitor responsible for quieting or deactivating neurological circuits, which can dampen fear responses in the amygdala. Austin James (2010) argues that kensho (unitive experience) would achieve the activation of the networks associated with other-awareness and the dampening of fear responses and egocentric circuits.

have long argued for ways that moral codes, autobiographical memory, conceptual regimes, and implicit assumptions like embodied schema constrain perception and sensation. This is what is often called top-down processing. To research bottom-up processing is to study how conceptual, moral, or schematic reasoning emerges from perceptual and affective experience and is encoded in memory. Contemporary empirical data, inconclusive yet persuasive, suggests that bottom-up types of processes like the open monitoring aspects of mindfulness meditation have great therapeutic value (Van der Kolk, 2015).

Mindfulness provides meditators space in which to step away from habitual thoughts, feelings, and perceptions in order to decenter. As meditators become progressively absorbed, they become the vessel of open awareness that attends to others. Via deepening mindfulness practice, mediators open their consciousness to novel perceptions and sensations that free their sense of self from habituated maladaptive thoughts and emotions. This is of great value to the practice of spiritual care in biomedical institutions in the US, which have toggled between the work of healing and the work of self-transcendence from its very beginning during the early twentieth century. Freeing one's sense of self from harmful thinking and feeling is of great therapeutic value, and therapeutic value is an important consideration when trying to heal wounded hearts and minds.

Freed mind-bodies find the means to transcend self-interest. Transcendent moments inspire healing, and healing is one of the essential consequences of hearing each other's stories. In a contrary vein, a fearful symmetry emerges in interpersonal relationships and social structures when emotional disequilibrium reigns. Patients and chaplains cannot arrive at the state of bodily peace that deeply listening to another human being requires by thinking themselves into that space. They need to attend to regaining balance in their sensational affective organism to find connection with others that takes them outside of their concern for themselves. For example, Van der Kolk (2015) writes of how drama therapy has helped to heal traumatized youth. "Mirroring loosens" preoccupations "about what other people think of them," he says, "and helps them attune viscerally, not cognitively, to someone else's experience" (Van der Kolk, 2015). Freed from self-interested thought and attending to others, youth recovering from trauma feel the inner world of their trusted group members which frees them from their self-preoccupations.

Empathic mirroring and compassionate response clearly see the suffering of others, embrace that suffering, counterbalancing painful resonances with the wise wish for others to find freedom from the harms that beset them. It is as if caregivers, patients, and families are rowing in a boat together. Should they all list to the same side at the same time, they would surely capsize and all end up in the water. Should they all veer toward fear, anger, and reprisal in unison, they all would risk ending up as swimmers far from shore. At the same time, the leaning body of another predisposes them to empathically lean in the same direction. Thus, the trick is to see the other as a differentiated part of the same system, to hold the other in tension with one's self. If one caregiver sees the listing of her next companion on the bench to the left and counterbalances her toppling, they both might have a chance to remain seated at their oars. Caregivers know this intuitively, but now neurophysiological approaches explain with greater understanding how social relationships shape neurological structures. There is a language for explaining how the compassion one feels for others counterbalances the suffering one sees in the world. These feelings of compassion necessarily entail action on the behalf of others. Chaplains can explain how empathic elements serve as inputs to compassionate responses that transcend empathy (Halifax, 2018). One not only sees and resonates with suffering (empathy), but one wishes that the sufferer might be free of suffering and then takes motivated actions to set the sufferer free. New maps of the nervous system have improved the scientific view of how human bodies and nervous systems in relationship maintain the complex balance of mutually supportive care.

What does meditation have to do with it?

Stories are necessary for the integrative healing enabled by two or more people who deeply listen to each other. Yet stories also tend to reify one's identity and reduce one's flexibility to hear another perspective in conflict with one's story. As anthropologist Jackson (2002) made clear, stories rework subject and object relations, so that someone victimized by violence whose body was the object by which a perpetrator wounded their selfhood can return to the position of subjectivity (Jackson, 2002). Survivors tell narratives about themselves in order to find a sense of belonging in a local world. They find their social location in the act of telling a narrative about themselves in relation to the social context in which they find healing. By telling their story to a receptive audience, victims rediscover social belonging. They discover themselves as survivors. "To belong is thus to believe that one's being is integrated with and integral to a wider field of Being," Jackson (2002) writes, "that one's own life merges with and touches the lives of others" (Jackson, 2002). A survivor tells a story that means she is not longer imprisoned by the lingering effects of silent shame. Through telling a story, she navigates between the personal and public worlds. All the same, once a survivor begins to tell stories that hold others accountable for her suffering, it is often difficult for her to refrain from blaming perpetrators for aggressive acts that threatened her being. Some survivors tend to blame others in their stories for the suffering others caused, and this work of blaming often occurs implicitly. Survivors often narrate their

stories in such a way that they reaffirm their own goodness at the expense of their enemy's badness.

But survivors also tend to evaluate themselves as lacking or faulty, as damaged and defiled, as inferior along any number of axes in comparison with others. A survivor might find herself playing the game of feeling superior to some and inferior to others. She may feel superior for her righteous suffering and endurance. She may feel inferior because of her vulnerability and complicity. These narrative and evaluative schemata often populate the mind of survivors without explicit awareness. In support of this view, recent research shows that the when the brain is idle default mode network that link together the midline brain regions that highlight the self and spin narrative interpretations of experience (Vago & David, 2012). This is task negative behavior, meaning it occurs when subjects are not actively engaged and focused on a task at hand. Vago and David (2012) offer their position based on the empirical data that "maladaptive habits, distorted perceptions, and biases accumulate through the conditioning or reification of the narrative self, most of which is not accessible to conscious awareness." Mindfulness meditation practices, and other formed of focused attention practices, act as "the master regulatory mechanism for de-coupling and efficiently integrating experiential and narrative self modes of processing with the potential to transform the reified self from maladaptive trajectories into more positive, adaptive trajectories" (Vago & David, 2012). Through increasing skill in mindfulness practice, one can down-regulate fear, rework and extinguish biases, and learn to clear the interior spaces of mind, nervous system, and body to receive others in their fullest expressions.

Focused attention (FA) contemplative practices include mindfulness meditation, centering prayer, Tibetan Buddhist versions of *samatha*, and Japanese *zazen* just to name a few of the more well-known forms it takes. Some recent scholars argue that yoga is a FA mindfulness practice that uses postures to activate and mindfully engage with bodily sensation (Emerson & Hopper, 2012). In any event, as Fox et al. (2016) summarize in the their meta-analysis of contemplative neuroscience research on focused attention meditation that these forms of meditation practice cultivate insular cortex, sensory-motor cortex, and the dorsal anterior cingulate cortex activation, while dampening the activity of the thalamus (Fox et al., 2016). The thalamus functions like a gatekeeper of neural information entering the brain, and meditation gives one more control over this neural structure. Focused attention meditation gives one greater ability to integrate bodily sensations of the viscera, which is associated with the insular cortex, into consciousness. Focused attention meditation allows one to change one's relation to bodily sensation in such a way as to adjust the function of the thalamus to permit more bodily sensations to enter into the conscious mind. In effect, meditation strengthens self networks that promote de-centering from one's cognitive and evaluative experience, so that the meditator can attend to others with less self-preoccupation and more skillfulness. One is no longer the central character of one's story, but caught up in a vast ensemble of characters. Mindfulness practices promote tolerance of distressing stimuli in the body and greater tendency to approach negative stimuli (Davidson & Begley, 2012). Mindfulness helps one place one's awareness outside self-referential thinking.

Do these brain studies describe exactly what happens when a skilled chaplain frees her mind from self-referential thinking so she can focus on the story and embodied experience of patients and their families? Does neuroscience research provide maps for the brain correlates activated when a chaplain leans into uncomfortable, ambiguous, or disquieting emotional content or conflictual family or institutional dynamics? Unfortunately, neuroscientists have not confirmed through empirical study that these neural linkages become activated when a spiritual caregiver listens to a patient. Research on spiritual caregiving has not confirmed the neural correlates of compassionate spiritual caregiving through brain imaging studies that map the brain activity of chaplains in the act of giving care. It would be rather difficult to gather such data, and would mean expanding the studies of contemplative neuroscience from relatively unspecialized beginners or expert meditators to other practitioners of compassionate arts. Therefore at this point, one can only infer that the activation of the neurological ensemble I point to above is what happens in the brains and bodies of chaplains when they listen compassionately to persons, families, or other caregivers in crisis. At the same time, I would defend my view that it is justifiable to infer that chaplains can feel viscerally the stories of others based on the neurobiological research data and theories culled from controlled studies conducted in laboratories.

Does research prove that compassion actually leads to better medical and spiritual care for patients and their families in healthcare settings?

The simple answer is: not conclusively, at least empirical qualitative study has not so demonstrated yet. Studies suggest that compassion training enhances care, but the methods for researching character traits like compassion in an empirical way that takes into account patient perspectives and interweaves subjective and objective data are newly emerging. Researchers on the effects of compassion in caregiving have yet to demonstrate convincingly that compassion produces measurable outcomes for patients. A recent scoping study by Sinclair, Norris, et al. (2016) points out the the marked lack of empirical evidence for the effects of compassionate care. Only two of the 648 studies they studied analyzed actually included any reference to patient experience. The qualitative study of patient notions of what comprises col-

laborative compassionate care remains shrouded in the mystery of silence. As of yet, patients have provided feedback mostly through satisfaction surveys and patronage of medical institutions that they prefer. Most of the studies analyzed by Sinclair, Norris, et al. (2016) or Pfaff and Markaki (2017) referred to the experiences of caregivers (Pfaff & Markaki, 2017; Sinclair, Norris, et al., 2016). Moreover, many of the studies lacked a clear definition of compassion that differentiated it from other forms of interpersonal feeling like sympathy and empathy (Sinclair, Norris, et al., 2016). For these and other reasons, Sinclair, Norris, et al. (2016) lament, "compassionate care is expected by patients and is a professional obligation of clinicians; however, little is known about the state of research on clinical compassion" (Sinclair, Norris, et al., 2016).

As contemplative neuroscience gains precision in differentiating the neurological correlates of compassion from empathy, further study of what compassion means to patients and their families in clinical settings is needed. While it makes sense to base healthcare's vision of what compassionate care looks like in empirical sciences like neuroscience, it also makes sense to incorporate the patient's vision of what compassion is as well. Coordinating between qualitative research that includes patient accounts, neuroscience studies, and religious traditions will produce the richest descriptive and predictive models for collaborative compassionate care. However, at this point, few researchers have included the patient view on what compassionate care means to them. Nor have many researchers attempted to measure the effects of compassionate care on patient health outcomes. Empirical, qualitative study of compassion in live settings, in the field of healthcare, might support or contest the intuitive notion that compassion actually improves caregiving. As Sinclair, Norris, et al. (2016) state, such studies that take into account patient experience have yet to be done.

It is clear that very little meditation training provides marked benefits in terms of neural integration to religious adepts with over ten thousand hours of time practicing open compassion (Goleman & Davidson, 2017). It seems that the reason for this is that human beings have basic neurological structures that strengthen empathic resonance, perspective taking, and compassionate response. Humans are designed to support one another in close-knit communities as the evidence from neurophysiological studies conducted by Porges (2017) so ably demonstrate (Porges, 2017). Compassion happens for most people quickly and effortlessly given the right conditions, that is when caregivers are not distressed and riveted on their own survival. At the same time, the greater the time cultivating compassionate response through mind training, the more robust and instantaneous the compassionate response of the caregiver. Tibetan adepts studied by Richard Davidson like Mingyur Rinpoche show nearly instantaneous control over activation of the neural networks correlated with compassion and much thicker interconnection of neurons in these regions (Porges, 2017).

In addition, the effects of lovingkindness and compassion meditation appear quickly in novices practicing meditation; they seem to take place after as little as eight hours of practice (Porges, 2017). What is less clear is how these effects cross the boundaries of physical bodies. If I interact with a compassionate yogi like the Dalai Lama, how quickly will our interactions have a dose effect that changes my internal states and character traits? How can these changes be measured? Is it enough to know them merely through subjective reports or is it necessary to correlate images of changes in the neural structure of patients with subjective reports of wellbeing? My sense is that the more sources and kinds of data caregivers have, the more comprehensive their view of caregiving will be and the more skillfully they will be enabled to care.

In another study published by Sinclair, McClement, et al. (2016), a grounded theory approach revealed that palliative care patients often associated compassionate care with caregiver virtues that they preferred. Patients cited a host of virtues caregivers displayed that embodied relational communication and person-centered care like "demeanor", "attentiveness", "vulnerable affect", "listening and supportive words," and "attending to needs" (Sinclair, McClement, et al., 2016). Indeed Pfaff and Markaki (2017)'s study advanced the over-arching finding that "patient and family centeredness" is "the primary structure for collaborative compassionate care" (Pfaff & Markaki, 2017). The essence of compassionate care is valuing people more than rational bureaucratic processes of caregiving that govern the provision of care in clinical settings. Sinclair, McClement, et al. (2016) suggest their study is preliminary to systematic research on compassion once an empirical measure like a compassion inventory is developed from work like their own. They say, "a measure would provide the means to conduct future randomized controlled trials and to evaluate education interventions" designed to train caregivers to be more compassionate (Sinclair, McClement, et al., 2016). Can Sinclair and his team's work add to the current discussion on the value of compassionate care to social healing as a form of justice? If so, how?

The state of research supports the conclusions that compassionate responses involve neural circuits that are different from those activated during empathy. Compassionate response converts the emotional resonance of empathy into actions on behalf of the suffering person the awakens feelings for another. By converting empathy into activity to help, compassion has a prophylactic function. As feeling and motivated action, compassion integrates the brain (Siegel, 2018). Compassion has a protective function for the brain whereas empathy does not, because compassion translates one's feelings for another (empathic resonance) and think-

ing like another (perspective taking) into action on their behalf (Klimecki, Leiberg, Ricard, & Singer, 2013). If more empirical research showing the results of compassionate care on patients existed, it would strengthen my argument here. As it stands now, what research exists points in the direction of compassion being a key ingredient in caring and supportive interpersonal relationships in medical institutions and beyond. As Sinclair, McClement, et al. (2016) find, communicative practices that make space for listening to patient stories, complaints, and concerns are essential to compassionate, person-centered care. Collaborative compassionate care involves feeling for, understanding, and taking motivated collaborative action to improve the situation of someone in pain or moral distress. This kind of caregiving has noticeable but limited positive effects on caregiver and patient alike.

How do stories heal wounded bodies and minds?

Storytelling events have profoundly integrative consequences in personal, interpersonal, and social dimensions. The human nervous systems and the human brain are complex systems that maximize the differentiation and integration of function and experience. The biological fact of neural differentiation and integration has important implications for storytelling and its ability to heal wounded persons. Once a person has regained a social context characterized by physical safety, they can again access their social engagement network. If the wounding they suffered is extremely prolonged or takes place early in life, the psychological patterning caused by trauma and abuse requires more energy and effort to undo. In any event, the survivor of trauma often regains a sense of internal cognitive and affective coherence but faces significant disintegration of memory. Fragmented memories lodge in the implicit memory systems of her body, triggering drastic and startling overreactions to common stressors. Traumatic memory intrudes in daily life and disrupts social interactions. In the context of a securely attached and attuned relationship, a survivor has the opportunity to rework and integrate these memories and achieve greater awareness of the wholeness of her being.

Research that describes the neuroanatomy of traumatic memory explains how amygdala-hippocampus-neocortex relationships, under the influence of stress hormones and sympathetic arousal, prevent the integration of implicit traumatic memory into a survivor's explicit memory and awareness. Since the right and left hemisphere of the neocortex are associated with different functions necessary for storytelling, a story strengthens the connective fibers linking the left to right hemisphere of the brain through the corpus callosum (Siegel, 2011). Since the right hemisphere links with bodily experience, left and right hemispheric integration also brings bodily experiences and memories back into conscious awareness. The linguistically adept and linear left hemisphere incorporates the bodily awareness, emotional experience, and autobiographical memory of the right. Thus in the aftermath of trauma, coherent storytelling reassembles a whole self (Siegel, 2011). This whole self integrates experience laterally and vertically. Without trusting and safe relationships in which to explore and integrate these fragmented bodily sensations, affects, and emotions, they linger in the relationships between the extended nervous system and body and resurface in intrusive ways. I would argue that everyone carries such fragmented memories in their interior world, to greater and lesser degrees, and these fragmented memories tend to resurface especially in moments of crisis. We are all survivors of various sorts of traumas, and we all need attuned listeners to hear our stories.

This is why spiritual caregivers play such an important role in clinical and penal settings. This is also why Willingham says spiritual caregivers have a social role that extends beyond clinical and penal institutional contexts. Contemplative chaplains have the training and inner dispositions cultivated through spiritual disciplines that dampen fear responses so that they can maintain a receptive stance toward stories that other people are habituated to deny. An attuned caregiver provides the social space in which a trauma survivor can then knit themselves back together. Trauma and illness survivors need an interpersonal context in which to heal, a social space in which to discover the moral lessons that trauma and illness teach. In the trusting interpersonal context established in a support group, attuned family, or therapeutic relationship, survivors can exercise ever greater self-autonomy and self-empowerment as a means to integrate themselves as they recover their stability and self-possession.

Telling stories, in combination with contemplative practices and other means by which to improve social and emotional resonance, promotes the integration of bodily sensations and implicit memories that trauma lodges in the body substrate. Mindfulness does this by strengthening the connection of the insular cortex, anterior cingulate cortex, dorsal and ventral prefrontal cortices, thalamus, brain stem nuclei, and distributed nervous system that always and everywhere collaboratively shape consciousness with the inputs of bodily tissues. Storytelling does this by interlinking the left and right hemispheres of the brain with the hippocampus and distributed nervous system. The strengthening of these neural networks is correlated with greater awareness of the interior, visceral states of the body,[13] increased ability to inhibit or modulate fear, and the improved ability to empathize with or intuit the minds of others. Hence, once a person reintegrates her experience after surviving trauma, she will herself be in a much better position, because of her changed neurobiology, to offer attuned care to others. Moreover, her visceral experiences of healing will likely inspire her. She will learn

[13] See Antonio (2018)'s final chapter of The Strange Order of Things.

from her own suffering and healing to offer compassion to others. This, in part, explains the preponderance of spiritual caregivers who themselves first benefited from another's care in a time of crisis.

What are the social and institutional consequences of spiritual caregiving in the culture of sexual violence?

Most of us in an academic setting openly acknowledge that certain types of bodies have suffered more intensely and more often than others in the history of our nation and world. In the context of a religious communities, some of the most persuasive voices in Zen address how race, gender, and sexuality mark experiences with suffering and the path to liberation.[14] The question is what to do about these problems of unfair treatment of socially marginalized others. At this point in my argument about the value storytelling and attentive listening, I want to narrow on only one of the three dimensions—race, gender, and sexuality—to explain spiritual care's essential role in healing from sexual trauma. Sexual trauma and interpersonal violence are rife in today's world and have been throughout history it seems. Consider that numerous women and men belonging to every social, ethnic, and economic group have survived sexual violence in various forms throughout history. Recently, public health researchers have publishes results that make it clear how frequent sexual violence occurs. For example, Breiding (2014) reports that "an estimated 43.9% of women and 23.4% of men experienced other forms of sexual violence during their lifetimes" (Breiding, 2014). These "other forms of sexual violence" do not include rape, but they were sexually coercive and aggressive acts that caused psychosocial harm nonetheless. Such are the realties of violence in the social history of our species in the US and worldwide.

All this data about sexually-based interpersonal violence says unequivocally that the scale of violence that human beings experience in the late modern context is so vast and the damage so great that touches all of society of some way or another. Currently, health systems and universities are establishing more violence prevention programs or supporting more comprehensive healing efforts that survivors and bystanders can implement and access to prevent or heal from sexual trauma. The most pernicious aspect of unaddressed sexual trauma is that the damage tends to fester if unattended. While race, sexuality, and gender mark the particular forms of traumatic imprint in any body with different degrees of severity, all bodies wither in their exposure to the traumatic forces widely distributed throughout late modern societies. Sexual violence is intersectional, the more dimensions of one's marginalization from resources and power heightens one's risk, but it is also commonly experienced by powerful and well-resourced women. It makes sense to pay greater attention to healing in historically marginalized groups, but access to healing practices needs to be widely distributed throughout society. The violence is everywhere, and so is the need for healing.

Social movements like the Movement for Black Lives or metoo argue for extending preventative methods and healing practices into marginalized communities with unprecedented intensity. In this work, forms of compassionate caregiving could play a significant role as movement, clinical, and penal chaplains introduce spiritual caregiving interventions like empathic or deep listening, person-centered spiritual care, and the ministry of presence. Making collaborative compassionate care the standard in healthcare could greatly improve the quality of care in hospitals, hospices, and health clinics. The primary mechanism by which to stabilize marginalized communities is to ensure that social institutions distribute material resources, such as medical and spiritual care itself, more evenly across social groups so that more groups feel safe, cared for, and resourced to face the daily challenges of life. As a secondary measure, social institutions need to attend to the work of spiritual healing, personal and interpersonal integration, and transcendence. Social and economic equality are naturally linked, and social justice cannot attend to one and ignore the other.

In this spiritual work, it is not so much that social institutions need any particular type of narrator to stop telling stories, though the leaders and members who participate in social institutions may need to increase the attention paid to black, women, LGBTQI persons in the social sphere. Bringing marginal perspectives to the light of the public sphere involves two steps. First, social institutions like hospitals and universities need to engage in qualitative study of the perspectives of these marginalized communities so as the figure out what they think compassionate care looks like. In the instance of sexual violence, how do sexually violated people suffer and what does compassionate care look like to them? Qualitative studies of these perspectives need to be understandable to broader publics in the public sphere. Second, social institutions like hospitals and universities need to equip more audiences—through practices that cultivated receptivity to otherness like decentering and cultivating a nonjudgmental listening presence—to value all stories no matter the harsh truths that they tell. Careful research has proven that mindfulness mediation practices can enhance these character traits associated with empathic and compassionate presence, (Goleman & Davidson, 2017; Vago & David, 2012), but other spiritual disciplines might do so well. Analysis of complex trauma argues for the application of such spiritual interventions at several levels: social, interpersonal, and personal. This is so because this not a problem confined to any particular set of social institutions, but is shared across organizational fields like health care, education, the military, and government.

Along these lines, the research of Felitti, Anda, Lanius,

[14] See for instance Manuel (2015) and Brown (2018).

Vermetten, and Pain (2010) on the pervasiveness of trauma indicates that complex trauma contributes to diverse problems like imprisonment and chronic medical conditions.[15] One of the legacies of the growing awareness of complex trauma in the therapeutic community is that it caused the type of long-term irremediable interpersonal dysfunction in patient populations that led trauma theorists to formulate a new diagnosis and approach to therapy. The attachment, self-regulation, and competency (ARC) framework developed by Kinniburgh, Blaustein, Spinazzola, and Van der Kolk (2017) at the Trauma Center in Brookline, MA recognizes the desperate need to stabilize family systems, attachment networks, and the physiologies of children and parents threatened with systematic violence (Kinniburgh et al., 2017). The self-regulation of child affect can only take place in the context of stable parental attachment relationships, so effective therapeutic interventions must first stabilize parents and caregivers in relationship with their children. Stabilized children, parents, and caregivers regain the capacity to access the integrative work of story that connects the members of family into one compassionate community. Once the symmetry of parents and children collectively regulating affective experience prevails, stories offer human communities an invaluable way to become aware of, regulate, and transcend the personal self.

Without the co-regulation of affective experience, a fearful symmetry in the form of a negative reciprocity threatens to plunge families, communities, and societies into chaos. The lex talionis rule of this state of affairs is, "Because I have suffered, now I will make you suffer. Because I have received punishment, now I will punish you." One merely translates between modes of exploitation and predation, turning one's history of victimhood into a justification to victimize others. That this occurs is natural. The transcendence of this vicious circle is just as natural, once the members of human communities regain their freedom to act with care for one another. Often the rule of violent retribution functions implicitly, schematically, and without self-conscious awareness. It is the ghost that animates the machine of punishment in a society that no longer finds displays of punishment in the public sphere palatable. Here is where spiritual caregivers can take part making the sacred space where survivors can beat swords into plowshares. To keep creating ghettos of interpersonal punishment, in Folsom State Prison or Appalachia or Yemen or South Chicago, is not a socially sustainable or socially responsible solution to violence on the global scale. Such a way of handling violence leads to shrinking islands of peace. To silo such interpersonal dynamics of violence can only presage more widespread social harm.

Conversely, to create an inspired host of receptive spiritual caregivers does some amount of good in a world where violence touches the lives of so many. If a spiritual caregiver cultivates the emotional balance and moral intelligence to listen to someone else's story, she can open new worlds of healing between herself and the person she hears. These worlds of healing have no natural limit: they have in them the energy of the infinite—a quantum holism. This hearing then enables greater interior integration for the spiritual caregiver, patients, families, and whoever else participates. The gift of listening returns to the caregiver in the form of greater insight about herself in relation to others. A similar alchemy happens for anyone else who takes part in the work of relationship. Separated by their various bodily imprints of violences suffered, caregivers and patients can tend to each other with care, like the right hand that bandages the left hand and the left hand that bandages the right hand that both have but recently escaped the flames. Better to heal scorched flesh than to make sure all humans are equally licked by the flames of suffering.

It is a dire need to understand with more clarity the contribution collaborative compassionate care has to make in medical and spiritual caregiving through more robust empirical study. In this pursuit, researchers have failed to sufficiently tap into the data that ethnographic study of patient views reveal about how patients perceive of compassion in healthcare settings. Maybe the stories that patients tell of excellent and substandard care, collected by diligent ethnographic researchers, can eventually serve as the exemplary tales that guide the skillful care of chaplains, nurses, and doctors in the context of a drastically altered health system will focus on person-centered care. Maybe this person-centered health system will support modest but sustainable reforms in social institutions more broadly that value the bodies, minds, and experiences of all more equitably.

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