Chapter 14

The Practice of Whole Person-Centred Healthcare

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In the spirit of being whole person centred I will start with a story (some details are changed or not included to ensure confidentiality):

14.1 A Woman with Skin Disease

Recently I was consulted by a woman with a 35 year history of a disfiguring skin condition complicated by a crippling arthritis. She had sought help from many practitioners, orthodox and unorthodox. Despite much medical treatment it remained out of control. She admitted quite spontaneously that she had moved quickly from one promising healing modality to another. She asked for help from me because she had read in a magazine that I looked at the ‘whole person’. The unaddressed story that unfolded in our meeting began in her family of origin. She was conspicuously clever. In contrast, her sisters were more oriented to traditional domestic roles. Her father could appreciate the sisters’ practical skills but could not validate her inclinations and academic achievements. As a young adult she spread her wings and travelled widely. Again in contrast, her sisters were all mothers by the age of 21. In her late twenties she married and conceived. The comment in the wider family was “Oh my God, she is going to have a baby!” The sense of inadequacy and self-doubt was steadily accumulating. The birth of her baby was a disaster: a very prolonged delivery in a remote setting, a genuine risk of both baby and mother dying, the baby with the cord tight around its neck and snatched away after delivery for resuscitation, the baby not held for two days and ensuing poor bonding, and a crushing sense of powerlessness and loneliness. She struggled with the child for years and while he was still an infant the father left the marriage for one of her friends. She blamed herself, her inadequacy, for this. The skin condition began and has continued ever since. She

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215

noted that it got much worse after another of her children suddenly died of unknown cause. Another child has developed a different serious inflammatory disorder. One way and another she blames all this on her inadequacy. There were some hints of very early sexual abuse. Notably, she described herself as struggling with something “ugly and dark” within her.

The question of course is why would I bother to take out such a history in a person with a serious medical condition? My reactive response is simply this: why not? A more considered answer is that the story seems really powerful and that from a unitive, nondualistic, whole person-centred perspective, in which mind and body are not separated in the ways we have traditionally accepted in medicine and culture generally, it is very likely these story factors are playing a significant role in her suffering and disease.

14.2 A Professional Evolution

In 1982, in mid-life, I abandoned a flourishing academic clinical immunology career, at the Christchurch School of Medicine, to train in psychiatry. I was responding to an increasing sensitivity to fragmentation. I had been reared within a Christian spirituality largely unaffected by science and modern thought and scholarship. I had trained to high levels in internal medicine which largely ignored subjective experience. And I was yet to discover a psychiatry and psychotherapy largely ignoring the body. I felt that this systemic fragmentation was a fundamental cultural problem, but had little ability to articulate it, let alone convert it into clinical practice.

Thus began a journey specifically undertaken to explore relations between medical practice and patients as whole persons. I had the impulse but no real concept of what it meant and certainly no idea where I was heading. I was not popular. My highly esteemed mentor, senior colleague, and head of the department of medicine, Professor Don Beaven, gave a simple and direct response to this change in direction: “You are an idealist!” and of course he was right. Other colleagues and peers seemed to feel I was betraying an unwritten professional code. The forces maintaining normative cultural structures in medicine are very powerful.

Already having expertise in the body (or at least, *diseases of the body*), my first move was to embrace the ‘mind’. Entering psychiatry allowed me to begin this process, to maintain my medical functioning, and to earn a sufficient living to sustain my growing family. The four years in psychiatry taught me many interesting and useful things, but I found that as a medical discipline it was pretty much just as deeply embedded in physico-materialist and dualistic assumptions as my previous internal medicine framework. This was not what I wanted. I was seeking to understand *persons* and the potential for integration of all dimensions of personhood in our understanding and treatment of illness and disease.

Psychiatry does have an interest in those physical illness presentations known as *psychosomatic* conditions, but had long vacated interest or professional

responsibility for mind factors in all the other physical conditions, the ‘real’ (sic) physical diseases. Indeed, mostly, it was felt that the apparently *non-psychosomatic* conditions had nothing to do with mind or subjectivity.

Psychotherapy, on the other hand, held more promise, and so I veered away from psychiatry. New ‘worlds’ of thinking opened up cumulatively over many years, about the mind or the subjectivity of persons as patients. The most influential emphases were psychodynamic theory, infant development, stages of life concepts, family and systems theory, trauma concepts, object relations theory, interpersonal psychotherapies, self psychology, learning theory, narrative theory, and consciousness studies. These worlds had been entirely invisible to me previously as a clinical immunologist. They remain invisible to the vast majority of medical clinicians working in practice in the Western world. The point I make here is that there is a vast panorama of the subjectivity of persons excluded from the ordinary arenas of medical care.

Psychiatry was not a suitable base for further exploration. I initiated a multidisciplinary Centre (Arahura Centre, Christchurch, New Zealand) committed to the integration of high standard medical practice, psychotherapy, and spiritual values. All of the staff and trainees came from diverse Christian backgrounds and felt similar if not identical aspirations for integration. With two colleagues I mentored this unusual journey of integration. Over the next ten years what developed was a multi-dimensional, multi-factorial, multi-causal, and multi-methodological approach towards disease (vide infra).

Personally, I began a psychotherapy practice and re-ignited my role as a clinical immunologist. There was nothing particularly intentional or inspired about that decision—it just seemed a sensible way to continue my life as a clinician. But, to my surprise, startling and jolting things emerged. Before entering psychiatry I had enacted my clinical life largely by perceiving physical diagnoses and diseases. Now, as both a physician and as a psychotherapist, working with individual patients presenting with a wide range of physical conditions, I was still making diagnoses and treating diseases **but also** hearing ‘stories’ in the same clinical time/space. And I started to see connections between diseases and stories in many cases. Thus began my work with ‘Medicine and Story’ (Broom 2000).

14.3 Somatic Metaphors

What was more disturbing was that these stories suggested that some of the physical conditions I was treating were actually *symbolic*. I have written extensively about these (2, 3). I called these instances *somatic metaphors* (Broom 2002). There were sexually abused patients with oral and genital conditions. A patient with a facial rash keeping a ‘brave face’ on a partner’s depressive condition *and unable to talk about it*. A patient with years of crippling mouth ulceration resolved when she

finally talked to her daughter about leaving the Catholic Church. My books relate a myriad of such examples, in both relatively minor and also very severe and serious physical disorders, most of which could not be confined and dismissed as *psychosomatic*, in the old sense of the term. More than that, the stories couldn't be simply dismissed as retrospective, narrative constructions or interpretations. The stories appeared to be triggers of the disease. Many were very chronic and had failed to respond to biomedical therapies, but got better when these meanings were ascertained and worked with.

This was very challenging. Initially a major issue was scientific plausibility. How can very specific meanings get expressed in the body, emerging as a symbolic disorder? The dualistic model we are trained in treats the mind (with its meaning-making) separately from the body, in which meaning has no place or role in the aetiology and pathogenesis of disease. In the end, I had to toss this model away and start to think of persons as wholes. The dualistic model itself becomes the implausible construction of reality. Thankfully, in recent years this is becoming more mainstream, at least in wider culture, though it hasn't dawned significantly on medical practice.

14.4 Whole Persons in the Clinic

While I found all of this both exciting and difficult conceptually, the next important issue was how to talk to patients about mind and body connections. What I found was that if I was skilful and did not psychiatrise these connections, patients were by and large cautiously open to a multi-causal view of disease that included 'story', or subjectivity in general.

Instinctively most people know we are 'wholes', it is just common sense. Nevertheless, one reason why we may express our life struggles in physical illness is that we may be unable, for one reason or another, to find a better way to represent, express, and work through certain difficult or painful emotions and issues. But I gradually learned to educate, to warmly 'hold' people through their uncertainties, and to enquire in such a way and at a pace which enabled trust and safety to flourish.

Thus, skills were needed, beyond the algorithmic protocols of normative medical interrogation. A majority of patients love being treated as persons with stories, as opposed to just being diagnostic challenges and objects. We clinicians need to make room for these stories, and, contrary to what most clinicians assume, this does not need to be principally about time cost. Curiously, it is much more about generosity, safety, empathy, and simple information and education about mind and body connections (see www.wholeperson.healthcare for an expanded review of appropriate listening skills). But until clinicians accept that human subjectivity or stories play a role in disease development none of this is going to be prioritised.

14.5 Reactions from Colleagues

Another issue was how to communicate with my colleagues. Patients were referred to me as an immunologist for *immunological assessment*. I wrote report letters back to my colleagues which certainly offered that, but also, where relevant (and almost universally), the review was wrapped in or permeated by a story.

I was anxious about this initially. How would I be seen? Would referrals dry up? My practice flourished. Many family practitioners welcomed these more fulsome reports. The odd one was dismissive (usually reported by a patient). Many carried on as before, impressed by but seemingly unaffected by my educative reports. Increasingly doctors sent me their problematic patients—the people who did not respond to standard biomedical care. I became known as a doctor who could hold complexity. Some doctors embraced the approach and trained with me.

But I learned early that despite even overwhelming evidence of mind and body connectedness most clinicians want to stay with what they know and do, with their dualistic biomedical model, even if this is not in the best interests of their patients. As an example of this, there are a host of scientific psycho-neuroimmunological articles suggesting an impact on the immune system of psychological factors, stress or abuse. And yet again and again I have attended huge immunology conferences where there is clearly no interest in or evidence of any impact of this work.

This problem of the neglect of the role of the mind or subjectivity factors is both multifactorial and formidable. The issues include: vested interest based on training, time and income flow; the dominance of the biomedical model; default behaviours and skills that militate against listening; lack of psychological understanding on the part of clinicians; relational inadequacy; inability to cope with patients' emotions; financial, institutional, cultural and systemic structures that avoid human experience; the valuing of quantitative over qualitative evidence; and the difficulties of dealing with data that is not easily 'measured'.

14.6 Dualist Psychotherapy

But we pressed on. The numbers coming to me increased and I found myself needing psychotherapists to help me. I would assess the patients and refer them on to excellent community psychotherapists. A new phenomenon appeared. Psychotherapists are good with 'stories' but they often, by default, exclude the 'body' from their clinical working space. This would happen even if I sent a patient specifically for 'mindbody' psychotherapy for a physical condition like urticaria, eczema, asthma, irritable bowel syndrome, migraine and much more. I also discovered that the patients would not do as well as I had expected. On review, I found

these patients told me that they might introduce their physical symptoms in the session with the therapist, who then would typically ask if the patient had talked to the family doctor about it again. That is, essentially, the therapist was saying to the person, ‘take your body to the doctor, it is not my job.’ Psychotherapists are certainly conceptually more open to the mindbody connections, but in practice are as dualistic as doctors. So I established supervision groups for psychotherapists, and from that time only ever referred my patients to the eight therapists I had in mindbody supervision. The therapists themselves needed holding in a whole person-centred framework. The outcomes were much better.

The point is of course that all of us in our specialised clinical work are dualists to some degree. Professionalism and scopes of practice serve to keep us in our conceptual silos. Again and again I find myself reiterating the two bulwarks of whole person healthcare work. We need to have a non-dualistic view of persons and disease, and we need to have the skills to comfortably allow mind and body to be *together* in our clinical workspace with patients, and to listen and respond. We now have many clinicians who can do this. They do not need to be dually trained (Broom 2013), as I am in both medicine and psychotherapy. It helps greatly if different disciplines are in close contact, supporting (for example) the doctor towards stories and psychotherapists towards bodies.

14.7 Publications

Time went by, and eventually in 1997 I published my first book, *Somatic Illness and the Patient's Other Story* (Broom 1997), essentially to tell the story of physical illness as related to the predisposing, precipitating and perpetuating ‘story’ factors of causality, especially focusing on those diseases generally regarded as physical, but also those considered as psychosomatic. The principles of non-dual, unitive, whole person practice apply of course to all illnesses. The book provides many examples of the observed clinical phenomenology, and lays out in detail the skills necessary to provide treatments that actively integrate normative biomedical principles with story factors.

In 2007 I published a second book, *Meaning-Full disease. How Personal Experience and Meanings Cause and Maintain Physical Illness* (Broom 2007), systematically addressing and arguing a theoretical basis for seeing persons as wholes, understanding diseases as being expressions of wholes (that is, multifactorial, multidimensional and multicausal), and the benefits of treating them as wholes. In that book I drew on many resources and concepts that can contribute to such discussions. Once we escape the grip of strict scientism we can find help from many disciplines, such as philosophy, modern physics, complexity theory, cultural and trans-cultural studies, the arguments for and results of qualitative research, and much more.

But clearly the biopsychosocial model (BPSM), psychosomatic studies and insights, and psychoneuroimmunology (PNI) deserve brief further mention here. I have gained a lot from these perspectives, but I diverge from them in one crucial respect. All are permeated with a fundamental dualism or physicalist reductionism or both.

My view is that George Engel, the originator of the biopsychosocial model, was not particularly dualistic, but the vast majority since who have espoused the model are indeed so. I really tire of hearing clinicians claiming to *believe* in the biopsychosocial model, but essentially happily ignoring the role of psychosocial elements in the supposedly ‘real’ physical diseases.

For its part, the psychosomatic tradition keeps mind-oriented clinicians focussed on a small group of disorders that cannot be easily *explained* by biomedicine—as if subjectivity is really only relevant in this small grouping of disorders, which cannot be explained by the biomedical model. This is rampant dualism.

Psychoneuroimmunology presents a different story again. It is as if we can only accept a role for story if we can find a linear mechanism acceptable to the biomedical model. Therefore it is fundamentally body-focussed and reductive.

One might also think that narrative medicine and narrative therapies have a lot in common with my story approach. Essentially they arose out of the 20th Century post-modern ethos and cross-cultural studies. The narrative focus is important. Essentially it is about what sense people make of their illness. This is important but it is a sub-section of story-gathering. Story in the narrative sense is essentially *post-hoc*: that is, the physical disease arises because of purely physical factors and *then* is interpreted *after the event* in one way or another, according to one’s belief systems and cultural influences. Our work goes beyond that to understanding the role of story in ‘causing’ disease.

14.8 Human Infant Development

Let us consider a human infant in its earliest phase of development. What kind of concept do we have of that infant’s evolving dimensions of physicality (bodily development, growth, movement, coordination etc) and subjectivity (capacity for experience, perceiving, relating, thinking etc). Surely it is without question that these capacities emerge and evolve from the beginning, *together*. The subjectivity dimension is not some adjunct, latter-day appendage, a kind of discretionary item. The dimensions we call body and mind co-emerge, and are inextricably integrated. I and two colleagues have addressed this in a paper titled *Symbolic illness and ‘mindbody’ co-emergence. A challenge for psychoneuroimmunology* (Broom et al. 2012).

If mind and body are not inherently separate, why would we assume that, in disease, body is important but mind is not? The reasons given for this depend a little on one’s background, but include the sharp ‘turn’ to dualism attributed to the French Catholic mathematician/philosopher, Descartes, or the inherent dualism of language-making, or the primacy given to concrete measurable dimensions of reality, or the fears we have of revealing the harsh and vulnerable aspects of our personal experience, or the determined ‘disenchantment’ of the world during the last few centuries in the name of demystification, positivism, and mastery. Most likely all these have played a role.

But our whole person-centred phenomenology of disease suggests strongly that we must engage in a unitive view of persons as wholes, and treat diseases within that conceptual framework.

14.9 *Mindbody Healthcare*

Back to what that meant in practice for me. I worked at the Arahura Centre from 1987 until 2007. In the later years I initiated (2005) a multi-disciplinary Masters and Diploma Post-Graduate Program in MindBody Healthcare at the Auckland University of Technology, specifically aimed at experienced clinicians of all kinds (for accounts by the clinicians themselves see Broom 2013). I had long felt that what we must do was encourage clinicians to expand their practices to include a story element. I had done many well-received workshops and seminars, nationally and internationally, but became aware that for most people it was too hard to make the changes needed. Once clinicians accepted and embraced the concept of persons as wholes, they typically became much more aware of what they were not doing. Some wanted to apply it to everyone and soon became overwhelmed. Many did not have good listening capacities, did not know how to invite patients to reveal difficult things, were uncomfortable with emotions, feared running overtime, and simply didn't have a language for these kinds of conversations. Some had habits that they either couldn't or did not want to break. Some would try, and then run into trouble based on these issues. So we devised a program which got established at the University.

The multi-disciplinary side worked out very well. It meant everyone had to see the generic principles of conceptual understanding of wholes, multifactoriality and multidimensionality, and also see that the skills of listening to story were the same whatever discipline we were in. What was different was how this worked out in different disciplinary settings.

Commonly we saw a lot of personal confusion and incoherence developing for more than 50 percent of the students in the first few months as they started to transform their behaviours and practices. There are typical issues. How do I start a story conversation without alienating the patient? What do I do now that the story has come out? Learning not to jump to *fixing* things was a major hurdle for the body clinicians (doctors, physiotherapists). Understanding that most stories are about what and what has not happened in relationships was hard for some to appreciate. Some would jump at a meaning like a clinician would jump at the result of a CT scan, and then find the patient pulling away. Being person-centred rather than 'my expertise'-centred was a harsh lesson for some. Discovering that collaborative recognition, between clinician and patient, of just the fact of a connection between the presenting illness and the story might be in itself enough to settle an illness was an amazing experience for others. Wanting it to be that way every time was a salutary lesson for others, whose desire for mastery transcended their capacity for tolerating complexity.

We have trained some 70–80 clinicians in this way.

In the earlier years I commuted to Auckland to teach this program but in 2008 I shifted there to live. I continued the AUT program, and was invited to take up a position as an Immunologist at Auckland City Hospital. It was then 26 years since I had initiated and led the Immunology department at Christchurch Hospital. I wondered how I would fit, given all the developments in my thinking and practice over the years. It was nice to be back in an old familiar environment. I was determined not to badger people into my way of thinking, and more or less succeeded in that. Throughout my time there I continued to practice from a whole person perspective. This was respected and valued. It has always been important to me to be an excellent physician in a normative sense, and being amongst biomedically-informed colleagues helped me keep up that aspect of my functioning. For years now, we have had two to four Masters level students from the Department of Psychotherapy at AUT University on placement in the Immunology Department working with Immunology patients and supervised by myself and a very experienced MindBody Psychotherapist from AUT.

14.10 I Was Conflicted

But I often felt heavy after my days at the hospital, constantly aware of patients who were struggling because of inadequate purely biomedical approaches, or suffering unnecessary side effects of treatments, and who could have been helped by a whole person approach. I was conflicted. I am very fond of, and greatly enjoyed the company of my colleagues, but at times I became impatient and frustrated that they could/would not open themselves a bit wider for their patients. There was a genuine respect for what I was doing, they wanted me there, but generally they hesitated to do it themselves. Some things did change in the department. Most of the clinicians professed to be affected by the whole person approach, and there was a reduction in useless and pointless testing for many patients. But it didn't go far enough for me. Perhaps it was the idealist in me, wanting a more major re-orientation. One of my colleagues has an enthusiastic and competent grasp of the approach. And we have 14 specialist doctors from throughout the hospital who meet monthly to talk about and learn the approach.

We are truly faced with a conundrum. There is certainly a hunger for something different, more whole person-oriented, but there is a powerful inertia in the health-care system.

There is one thing more for this chapter. What is the cause of improvement in illness and disease when the whole person-centred approach is used? As stated at the outset, a major stimulus for me as a clinician was the phenomenology of symbolic disease. Thus a focus on meaning and stories of meaning-full disease became my initial doorway into the 'whole person'. But I have resisted a reduction of all

disease to meaning. Opening things up by going through the doorway of meaning mobilises many other elements, including the importance of relationship in healing.

The skills involved in listening to stories are mainly relational skills. Genuine interest, willingness to tolerate uncertainty, waiting to see what emerges rather than relying on prior knowing, warmth and empathy, and much more. Certainly not all patients had symbolic disorders. Most stories we dealt with were crucially about relational disturbance.

This leads to another issue. Clinicians, by virtue of their training, are very susceptible to learning a *methodology* that is based in searching for a story, or *the* story, like searching for a diagnosis or a pathogen. But once such a search is initiated they are confronted with what it means to be in a healing relationship with the patient in a much more intimate way.

Out of all of this, I came to suspect that much of what we were doing could be conceptualised roughly as follows. Meaning is important, and it is a physician's focus in opening up the field, in which it is accepted by the clinician and patient that mind and body are connected and need to be addressed in the proper treatment of a physical condition. Physician interest in the patient's meanings or story triggers in the patient a sense of being understood. Sufficient trust and safety can lead to the patient revealing painful and important material, and with support be nudged into resolving some long-standing issues, usually of trauma or disturbance in relationship. It might be enough just to name these, or a longer process of mindbody psychotherapy might be needed. At every point physical and non-physical factors are held to be potentially contributory.

All this might be the physician's interpretation of what is happening. But what do the patients say?

14.11 Being Looked at or Being Seen?

Galia Barhava-Monteith, a mature woman who had recovered from the serious disorder Churg-Strauss Vasculitis whilst undergoing both normative chemotherapy and a whole person-centred approach, recently completed a PhD (AUT University 2018) exploring this question, titled: *"The difference between being looked at and being seen": An in-depth consideration of experiencing the Whole Person Therapeutic Approach for chronic illness*". There are many important things to ponder on in this thesis. It is noteworthy that, in contrast to the perspective of whole person-centred clinicians as to what is important in disease treatment, few of the patients undergoing such treatment refer to the importance of specific meanings or symbolism in their stories of recovery.

It will suffice to use Dr Barhava-Monteith's own words:

I have come to see that the taken-for-granted practices of WPTA (*Whole Person Treatment Approach*) clinicians, or the *how* of their practice, is the thing itself. I now comprehend how the therapeutically beneficial aspects of WPTA, and any other encounter between two people where one's role is to enable the other to get better, are dependent on the capacity of the

healer to see the person they are trying to heal. The technical knowledge of course must be there, but it is only the starting point. I came to conceive that this experience of being seen is the feeling that someone else is truly seeing the whole of you. Risking hyperbole, I argue that this is a profoundly existential experience, as mostly we spend our lives with people who only look at aspects of us. Who look at our professional background, or at our symptoms, or look at our childhood trauma. From apprehending that the experience of being seen is somehow important, I now comprehend that it is an existentially humanising and healing experience that unfortunately too few people experience. My doctoral research has confirmed to me that being introduced to non-dualistic concepts as they pertain to health and wellness in the context of this relationship can be transformative, in that patients come to reconceptualise their identity with respect to their illness so that they, like me, can experience freedom and hope. However, I now grasp that to introduce radical new ways of thinking about one's self is something that should be treated with utmost care and reverence. Introducing such notions may destabilise the very core of one's personhood. Now I see that anyone who is involved in activities that are concerned with changing the way another person thinks and behaves, has to earn the right to do so. And the ways by which we earn that right is through being careful and mindful of our words, our actions and our capacity to recognise the personhood of another, and of being experienced as doing so. In a sentence, my conclusion at the end of my doctoral journey, is that it is through the *how*, not the *what* where profound experiences and changes occur... In concluding this doctoral thesis, I do think that making explicit the ontological dualistic assumptions underpinning much of the teaching of modern medicine is important. However, I now think that we need to consider shifting the almost exclusive focus on content or the *what* of clinical sciences, to include, as equal, the *how*, the ways of acting and being. My reflection in concluding this thesis is that clinicians who work to embody these humanising practices, are likely through doing and experiencing, to shift their own preconceptions about the dualistic nature of health and illness. (Barhava-Monteith: 230)

I finish as I began. In considering causality in illness and disease, our work draws attention to the fact that we, as patients, are persons, but more than that, persons-in-relationship. Any therapy that reduces us to a more limited view of persons, such as objects to be technologically manipulated, is going to have serious limitations, if not in many cases profoundly inadequate.

References and Further Readings¹

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¹For clinicians and others wanting ready access to a range of resources in Whole Person-Centred Healthcare there is a wealth of material at <https://wholeperson.healthcare>

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