AUTUMN 2015 VOLUME 5 NUMBER 1

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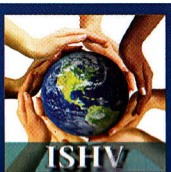

Published by the
Institute for Science and Human Values

CANCER AS EXISTENTIAL CRISIS: COPING STYLES OF BELIEVERS AND NONBELIEVERS — AND A ROLE FOR SECULAR HUMANIST CHAPLAINCY

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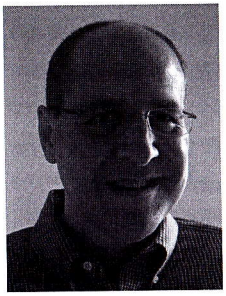

ABSTRACT: *Patients confronting cancer and other potentially life threatening illnesses often struggle with the need to feel in control, and with the need to find or make meaning in the face of their adversity. These themes express themselves differently in different individuals, influenced both by personality type and by worldview — especially religious/spiritual versus secular worldviews. Psychological difficulties in the context of cancer warrant a referral to a psychiatrist if those difficulties have become a source of functional impairment, such as disabling anxiety or depression leading to social withdrawal. Cancer patients with more average, expectable emotional and existential struggles can be served by other kinds of professionals. Among those other professionals are hospital chaplains, who often serve as a valued source of support for religiously oriented patients. Secular patients do not generally avail themselves of chaplaincy services, and chaplains tend to avoid engaging non-believers. This need not be so. Many chaplains are skilled at providing general emotional support. They are also capable of engaging in existential counseling without invoking "God-talk." Dr. Lewis is working with hospital chaplains in Toronto and at the national level in Canada to help them to better understand and serve non-believing patients. In the process, insights are being mutually enhanced as to how to help people deal with existential crises, including terminal illness, without belief in a higher power or belief that "everything happens for a reason."*

KEY WORDS: CANCER, COPING, SECULAR HUMANIST, CHAPLAINCY

Being diagnosed with cancer is a shocking experience for anyone. It suddenly converts people's abstract ideas about their own mortality into an imme-

diate confrontation with a very personal, very internal, physical existential threat. It initially hits people with a feeling of visceral, disorienting lack of control. As soon as they start to re-orient themselves from the initial shock and disbelief, most people start looking for ways to re-establish a reassuring sense of control. How they do so tends to be shaped by their worldview—in particular, whether they are religious or secular. In contrast, the intensity with which they try to achieve that sense of control seems to be largely dependent on their personality type. The existential crisis of cancer also raises questions of meaning. People take stock of the value and purpose of their life. Cancer forces people to reappraise their priorities in life. Some people wonder what the cancer itself means—did it happen for a deeper reason?

I work as a psychiatrist in a large university hospital.[1] My clinical work includes acting as a consultant to the regional cancer centre connected to our hospital. Common reasons for referral of cancer patients to a psychiatrist are disabling anxiety or depression. This would be more than the average anxiety and depressed moods that most cancer patients generally experience—rather, it is the kind of anxiety or depression that causes significant and sustained impairment in functioning. Psychiatrists help referred patients by engaging in "talk therapy" and, when needed, prescribing medication.

Depending on the type and level of psychological difficulty the individual is having, a cancer patient can be referred to a psychiatrist, psychologist, or social worker. In many hospitals, patients can also ask to see a chaplain. Conventionally, this is because the patient considers his or her difficulty to be of a spiritual nature. Hospital chaplains may provide fairly traditional religiously oriented counseling for those patients who identify such a need. They may also perform religious rites and rituals when requested, or participate in prayer with a patient. Fewer patients identify religious needs now than in the past. Where I work, in Toronto, Canada, hospitals are for the most part highly secular public institutions in a generally secular society. Chaplains play a secular therapeutic role too, even with their religiously inclined patients, often landing up providing more general supportive emotional counseling and meaning-centered counseling not necessarily within a religious framework. Many chaplains are quite skilled at this.

Most patients who are having some sort of emotional difficulty dealing with their cancer "just" need someone to actively listen to them with full attention, patience, interest, empathy, and a non-judgmental, reflective stance.

This is much harder than it sounds. And it can be time consuming. Not infrequently, such a patient in his or her distress is thought by the medical team to require psychiatric treatment, when the problem could have been averted by skilled active listening.

A struggle to feel in control

A middle-aged woman was referred to me by her oncologist because of great emotional difficulty coping with her cancer and its treatment—more difficulty than the average cancer patient. She was ambivalent and indecisive regarding every step in her cancer treatment, resulting in significant delays proceeding with necessary treatments. Her oncology team found her very difficult to work with. She consumed inordinate amounts of time from every doctor and nurse working with her, with her endless lists of questions and requests for individual accommodations. She had also repeatedly expressed suicidal thoughts to her doctors, which alarmed them. When I asked her about this in more depth, it was clear that she did not have any active suicidal intent or plan. She did not wish to die—she was afraid to die. She was terribly afraid of even moderate pain from cancer or its treatment. More particularly, she feared *any* loss of control, especially in the event of a gradual decline in functioning if her illness were to prove terminal. She had in fact been told repeatedly that there was actually a pretty good chance of treatment controlling and even eradicating her particular form of cancer, so long as she were decisive and proceeded with the recommended treatments. Yet she fixated on this fear of loss of control.

Talking to her clarified that the issue was more one of anxiety than depression. Her anxiety represented a heightening of lifelong anxious traits. She had always been an anxious, obsessive person and was a self-described perfectionist. Such traits ran through her family in relatively milder form. These traits of hers had never led to disorder of major psychiatric proportions, but had affected her life and life choices (career, relationships, family) in quite substantive ways. She had always had an intense need for control and certainty. She needed to research every decision option extremely thoroughly, gathering maximum information before acting. This had frequently led to indecisiveness, doubts about decisions that had already been made, inefficiency in her work, and narrowing of opportunities. She was an intelligent and hyper-rational person who was pursuing an academic career in a high-end scientific field. But she had been delayed by many years in achieving her

career goals, and continued to be, because of her anxious need for control and certainty. She had also decided not to have children because of the fear of loss of control over her life.

The abstract idea of suicide both terrified and consoled her. It represented for her the ultimate prerogative of asserting control over her life if ever necessary. This, even though she was not actually suffering pain or disability and despite her favorable prognosis. Not being a religious believer, and holding a strongly scientific worldview as she did, she thought that only she could or should be in control of her own life. She once commented: "I wish I was a religious person because then I would have someone to blame. If there is a God he's against me."

In her own particular field of work, she had been accustomed to much higher levels of precision and certainty and was frustrated by the uncertainties inherent in the experience of cancer and its treatment. Her oncologists were simply unable to give her the definitive answers she repeatedly sought regarding her prognosis, or the assurances she demanded regarding the uncertainties and risks of treatment.

Everything about her cancer experience and its treatment felt purely negative for her, including all her interactions with the many people trying to help her. The entire experience felt utterly meaningless to her. She could not possibly see it as anything other than a total derailment from her life's purpose—her career.

Personality type and the need for control

Some people just naturally have a stronger need to feel in control than others, and have a higher expectation of control. This is probably a constitutional trait, more pronounced in certain personalities than others. These kinds of people tend to be focused, organized, attentive to detail, careful, responsible, persistent, and highly motivated. They have a high capacity for self-control and willpower. In personality dimension theory,[2] this set of traits is referred to as conscientiousness. It is one of several major dimensions describing personality type. It can be recognized in fairly young children as a high capacity for emotional self-regulation and the ability to apply themselves to tasks requiring sustained effortful control. The underlying cognitive capacity might perhaps be a longer attention span, among other so-called

"executive" brain functions. Conscientiousness traits are generally a desirable set of attributes, but if they are too intense, they can impair functioning. These people may be perfectionists and can be compulsive, rigid, controlling, demanding, judgmental, and excessively self-critical.

People at the other end of this particular dimension of personality have a relatively lower capacity for self-control and a concomitantly lower expectation of control. They may even feel less *need* to try to control their environment and themselves. They tend to have a passive view of life events. They may regard events as simply happening to them without much feeling of agency over their lives. They view themselves as if in the passenger seat of their life, in contrast to high control people who view themselves as very much in the driver's seat. Although these low-control or low-conscientiousness types of people have many disadvantageous traits, particularly if they are on the far opposite end of the conscientiousness spectrum, they have a number of advantageous characteristics, too. These include flexibility, adaptability, spontaneity, and lower levels of stress and anxiety (of course, some passive people may in fact be quite anxious, their passivity being due to anxious avoidance). They are generally easy-going, "go-with-the-flow" types, in contrast to the tense, "go-getter", "control-freaks" at the other end of the spectrum.

Personality prototypes towards both ends of the conscientiousness scale have their strengths and weaknesses. As with all major dimensions of personality, most people have less extreme traits falling to one side or the other of this bell curve. Of note, much of the variance of major dimensions of personality across the population is accounted for by heritable "nature." But on account of the complex combinatorial permutations of genetic sorting, members of the same family can have very different natures from each other.

An intersection of worldview and personality type

Patients with cancer and other serious illnesses come with the full range of personality traits and coping styles. Quite independent of personality type, these patients may have personal beliefs anywhere along the full range of religious or secular worldviews. I am afforded the opportunity of observing trends in how different worldviews intersect with characteristic personality styles in influencing how patients deal with the existential crisis that cancer presents. I have had many cancer patients who are preoccupied with various attempts at "control." Their obsessive need for control manifests in ways

that vary depending on their background and belief system. I have also seen many patients with low expectations of control, for better and for worse. The table below summarizes my observations.

Worldview	Religious or spiritual		Secular	
Personality	High control	Low control	High control	Low control
Assumption	*"Everything happens for a reason"*	*"God works in mysterious ways"*	*"We can control our health"*	*"Shit happens"* (random or natural causes)
Emotional reaction	*"Why did this happen to me?"* (guilt, anguish, abandonment, **or** anxious motivation)	*"What will be will be"* (resignation **or** fatalistic acceptance)	*"What did I do to neglect my health?"* (guilt, self-blame, **or** anxious motivation)	*"I have little control over this"* (helplessness, passivity, **or** liberation from guilt/anguish)
Coping actions	Try to find "the reason" (which may mean the *purpose* of the illness), and address it religiously. Pray for salvation and mercy, bargain with God. Perform religious rituals, obligations, or confessions more fervently or more perfectly than before. For less fervent believers: intense "seeking" to discover spiritual meaning.	Hope for a favorable outcome. Pray to be granted fortitude and comfort. Submission to God's will, acceptance of Divine Providence. "It's in God's hands".	Assume maximum control over every aspect of one's health. Pay fastidious attention to every aspect of healthy lifestyle (diet, exercise, stress management, mind-body "holism", etc.). Need to be vigilant to the point of obsessiveness.	Simply "show up" for medical treatment—"it's out of my hands". No point obsessing with trying to control health. Rather focus on engaging in fulfilling activities and spending time with people. Just try to live fully, "here and now."

People with a high need for control, whether religiously inclined or secular, tend to have exaggerated, misplaced feelings of personal responsibility for their cancer. For example, a common tendency is for patients to greatly overestimate the role of their own lifestyle in the causation of their cancer. Such beliefs have unfortunately been reinforced by simplistic health education attempts in the public sphere. With the exception of well established risk factors such as smoking, extremely unhealthy diets, and excessive sun exposure, lifestyle factors—at least the potentially controllable ones—play less of a role in causing cancer than people tend to believe. Whether religious or secular, people don't like the idea that randomness rules their lives. For those high-control people whose secular worldview precludes a fixation on religious ritual, a common focus for their obsessive need for control is healthy diet and exercise. Even in the absence of a well established link to their particular form of cancer, they often suspect that they have somehow caused their cancer through insufficient attention to healthy lifestyle. They even more anxiously fear that they might adversely affect their prognosis through

insufficient vigilance to such factors. Moreover, I have had many patients who, influenced by media hype on holistic health, became extremely anxious *about* being anxious. They can become convinced that the "mind-body connection" is so strong that they fear they will jeopardize their response to cancer treatment as a result of the physiological effects of anxiety.

People obsessed with control often need help in prioritizing just *living* their life here and now. Their high need for control can become a seriously destructive distraction from relationships and other meaningful aspects of their lives ("Daddy, where's Mommy and when is she coming home?" "She's still at the gym, dear. She just texted me to say she's sorry she can't be home in time for your bedtime again, but she sends hugs and kisses.") To temper this, it can be helpful for them to recognize concepts such as risk-benefit ratio and the law of diminishing returns. The ratio shows that there is marginal health benefit from obsessive attention to diet and exercise, and it is counterbalanced by substantial risk of harm from the obsession. Likewise, there are diminishing returns in terms of additional health benefits when you go far beyond basic attention to healthy lifestyle. People obsessed with control need help in seeing that they are impairing their quality of life in the present by trying so hard to control the future.

Personally, I regard myself as being on the high end of the conscientiousness scale. For better or for worse, I have a higher inclination to want to feel in control. However, I am married to someone who is towards the other end of the scale. On good days, our traits complement each other nicely—her flexibility and adaptability counter-balance my obsessiveness. When my wife was diagnosed with an aggressive form of potentially very lethal breast cancer a number of years ago, I sprang into hyper-focused, goal-directed action. This was critically necessary at the beginning, until we were connected to expert services. But it could have become a problem. I was helped to relinquish control early on, when her oncologist assertively told me in our first appointment with him that I should step back and let him take over. He cautioned me to not attempt to check test results on our hospital's online patient records system. He advised me not to try to research and interpret medical information or make treatment decisions. He told me that he would direct her treatment from that point on. At that moment I felt like I had been standing outside my burning house with a garden hose. Several shiny red fire trucks with lights flashing and sirens blaring had just pulled up. Then, I had just been politely but urgently pushed aside, and told by the fire chief "You

can step back now sir!" I felt anxious no longer in control, but at the same time immensely relieved.

From that time on, we just showed up for treatment when told, and hoped for the best. We put our energy into our activities of daily living and into our relationship, our parenting, and our connections to extended family and friends. I don't want to romanticize the experience with the selective memory of hindsight, but some of our most moving and meaningful interactions with people occurred in our time of crisis. We were the grateful beneficiaries of very much kindness and caring (inevitably, a few people did not know how to relate or simply avoided doing so; a few others were overbearing in their caring). We had a great sense of clarity of priority and purpose. For quite a while we did not "sweat the small stuff" (unfortunately, human nature relapses far more surely than cancer).

Being non-believers who have many religious family and friends, we thanked people for their prayers and rituals, explaining that it was their caring that touched us. We politely declined to participate in any such rites or rituals ourselves, despite some pressure of expectation and tradition to do so. We were told things like: "What harm can it do?" and "Maybe you'll consider doing just this little thing... just in case. It could end up making all the difference—you never can know," and "I know someone who was also irreligious but she did it and she's in remission now despite the doctors having told her it was incurable."

Our experience of cancer is what later got me interested in redirecting some of my work to being a consultant psychiatrist to the cancer centre.

Meaning and mattering

Cancer usually brings questions of meaning into sharp focus. Humans are meaning-seeking. People ascribe functional purpose and value to nearly everything: objects, events, actions, and so on. People are highly reflective beings. This is partly a function of the recursive properties of our thought processes. The result is that people turn that valuation back inwards to assign meaning to their lives as a whole. As a fundamentally social animal, much of a human's self-valuation concerns his or her perception of his or her value and purpose to others, to the group, to leaders and higher authorities, to the whole—something greater than the individual. These needs are usu-

ally ever-present in most people, but they assume even greater importance when faced with an existential threat like cancer.

Fundamentally, people want to know that their lives matter. The question is mattering to whom or to what? Religious people generally want the universe, in a sense, to care. Secular people just want people to care.

Religious people often seek *the* purpose of their life. Their underlying assumption is generally that the universe and life are intentionally created and designed. Events may be viewed as being intended. The task of the believer is to try to discover and understand the inherent purpose of it all. Suffering must mean something. If the purpose seems obscure, it is because God's ways are mysterious and often unknowable to our limited human understanding. This must be accepted on faith.[3] The belief that "Everything happens for a reason" can lead to comfort for many, but others anguish over the question, "Why me?!" The sheer immensity and intensity of life's cruelty challenge the faith of many more people than is commonly assumed. Many people who profess their faith in public in the midst of adversity are confiding their doubts in their private conversations with therapists and with their religious ministers.

Nonbelievers don't believe that meaning or purpose are inherent or intended in events, simply waiting to be discovered. Rather, they generally take the view that stuff happens, and then they try to adapt and make meaning or purpose in new ways out of their new set of circumstances, as best they can.

By the way, you don't have to be on the low end of the conscientiousness personality scale to adopt the "Shit Happens" worldview. It just requires more deliberate rational effort to come to terms with its full implications, and it requires overcoming one's exaggerated sense of personal agency, and in a sense one's solipsism. For me, it's the only fully coherent, rational, evidence-based philosophy possible. It is devoid of magical thinking, wishful thinking, and other more subtle human intuitive biases. It is the worldview of naturalism. It has the full and unequivocal weight of twenty-first century scientific insights behind it in fields as disparate as cosmology, evolutionary biology, complexity theory, and neuroscience. We now understand how the universe, life, and consciousness *could* have emerged and evolved 100% naturalistically and spontaneously. In fact, the universe and everything in it looks exactly as it would be expected to, if it had evolved without any

planning or guidance whatsoever (this point can be persuasively made before even needing to invoke the "Problem of Evil: Why do bad things happen to good people?"). Any notion of foresight, let alone benevolence, is patently contradicted by a more thorough understanding of science, most especially evolutionary biology. And with regard to personal life events, critical thinking and an understanding of human cognitive bias should enable us to see past our human habit of thinking that everything happens for a reason and that it's all about us. Anyone who has been trained in the rigors of the scientific method's approach to establishing cause-effect relationships should *never* be impressed by random events that appear after-the-fact to have been imbued with self-reference or cosmic significance and purpose, including seemingly "spine chilling" coincidences.

In people's strivings to make meaning in their lives, relationships are usually particularly important. People generally want to know that their adversity matters to others. It is especially consoling if one can believe that something good might come out of something bad—perhaps some positive impact on others. Perhaps even more so in terminal illness, people tend to derive comfort from knowing that their lives matter and will have mattered to others. They will want to know that they have had some significant positive impact, leaving some sort of legacy. All this is of course important to believers, too.

The empathy and interest of others mitigate suffering by helping people to feel that they matter. People are often helped by having someone to talk with as they reflect on the meaning of, or in, their lives. It can help them process feelings of disappointment and regret. Care-giving professionals in hospital settings can play an important role in this regard. As a therapist in this role, I often emphasize the personal impact that my patient is having on me in the therapeutic relationship that we form. I try to express gratitude to them for sharing their life experience with me and for teaching me profound lessons about the human condition. I might also assure them that their impact on me and the lessons I am learning from them will be transmitted through me to other patients as well as to students, having a ripple effect on other lives.

A role for secular humanist chaplaincy

Among the various kinds of professional counselors working in hospitals, chaplains are a highly valued source of solace for many religious and spiritu-

ally inclined people. Secular patients have generally not had such a resource available to them—at least not in a way that a nonbelieving patient would feel comfortable accessing. Many patients need a skilled objective listener but don't necessarily need to see a mental health professional. Yet they are frequently referred to such professionals on the basis of moderate depressed mood or anxiety, among other reasons. Some patients referred to such professionals are socially isolated, but most are not. They may be surrounded by family and friends, but not feel able to talk frankly about their concerns, especially their feelings about death and dying. Family and friends have a tendency to shut down such topics, perceiving such conversation as too negative. Instead, they urge the patient to "Be positive and optimistic" or give empty reassurances that "You're going to be fine."

With these kinds of patients in mind, I am presently working with the chaplains in my hospital to re-orient and broaden the scope of their work to serve the large proportion of patients who are secular, and the increasing numbers who are outright nonbelievers. Many of the chaplains in my hospital are already accustomed to working with non-believing patients. Their training emphasizes being respectful of the diversity of patients' worldviews. Yet, not surprisingly, most nonbelievers would not consider asking to see a chaplain. Making the chaplains' work amenable to those patients may be more a matter of emphasizing aspects of what they already do. An important aspect then is for them to market and rebrand themselves in ways that will appeal to and feel accessible to nonreligious people.

What is needed in order to effect this change is to persuade the chaplains themselves that: (1) they are actually good at providing "meaning-centered" counseling (essentially, existential psychotherapy) and (2) they are able to do this without the God-talk. Doing so requires understanding more fully the nonbeliever's worldview and framework for meaning-making (as opposed to discovering meaning). This role would of course be in addition to the chaplains' still-needed traditional role for religiously inclined patients.

The chaplains I have worked with are actually very receptive to this input. They are trying to increase their relevance in this increasingly secular age, and reduce their vulnerability to hospital budget cuts. They are also interested in, and probably will be eligible for, formal registration as psychotherapists when the previously unregulated and undefined term "psychotherapist" becomes a regulated profession in our province, Ontario. Above all though,

they are genuinely motivated to help as many patients as possible. The kinds of people who choose to work as chaplains are usually compassionate, empathic, and reflective people. In the process of our discussions about re-orienting their role, they are also acquiring a deeper, more subtle understanding and appreciation of the naturalistic worldview.

The marketing of their chaplaincy services to secular patients requires tailoring the language describing their services in their brochures and on their websites accordingly. For example, a preliminary redrafting (not yet finalized) by the chaplains themselves of a description of their services in my hospital reads:

Chaplains/Spiritual Care Therapists provide emotional and spiritual support to patients and family members in exploring their beliefs and values and helping to discover or make meaning/purpose in living with cancer and life events; listening deeply to the person by exploring one's lifetime contributions, choices and legacy, reconciling losses in life, examining significant relationships, as well as facilitating religious needs and rituals where desired.

My hospital's Spiritual Care department has also generously invited me to participate as a committee member in their upcoming review and revision of their chaplaincy training program, as part of their site accreditation which takes place every ten years.

A living human document

Chaplaincy training emphasizes regarding the individual human life as a narrative, constantly in the process of being rewritten, a "living human document." The patient described earlier in this article struggled to integrate the cancer experience into her life's narrative and to give it meaning. She was fixated on cancer's disruptive, derailing impact on her career plan. She seemed unable to adjust her ideas about her life's purpose as she had previously defined it. In a sense, she could not rewrite her life's narrative to incorporate the cancer experience. Moreover, she could only see the interactions she was having with people during this experience as serving the single-minded utilitarian goal of fixing this mishap and getting her back on track to where she had been before she had been derailed by the diagnosis. It never seemed to occur to her that there could be something very meaningful and transformative taking place in the course of her receiving treatment for

the cancer: perhaps a new perspective and clarity on what is most important to her in her life, an opportunity to reflect on what she has achieved and what she still wants to achieve, with renewed motivation and focus, an opportunity to learn to be more flexible and adaptive, an appreciation of the experience of being the beneficiary of the dedication and caring of others, a heightened empathy for other people facing adversity, and maybe even motivation to help others in similar situations in the future—to "give back." This patient needed help in coming to terms with uncertainty and lack of control, and with reframing her experience to make meaning from it. She did not necessarily need to see a psychiatrist. She might have benefitted from the help of a counselor with the kind of skill-set described above, and that professional could have been a chaplain. I have chosen to describe a "difficult," challenging patient here. Most patients are easier to work with, and are very grateful to have someone take time and interest in hearing their story. Many patients land up telling the chaplain in whom they have confided that they have never before had such a candid and meaningful conversation. These conversations need not be about God, the afterlife, or supernaturalism.

"Spiritual Care Professionals" or "Chaplains"?

Canadian chaplains started referring to themselves a few years ago as "Spiritual Care Professionals," to replace terms like religious care or pastoral care. The assumption behind the change was "Doesn't everyone identify with spiritual needs?" I have been pointing out to the chaplains I work with that for people who consider themselves to be more definitively secular humanists or atheists, the word spiritual may not be a drawcard. That being said, it should be noted that some atheists do advocate use of the word "spiritual" and argue for redefining the word in purely secular terms. For example, Sam Harris does so in his new book.[4] I am suggesting to our hospital chaplains to rather use language like "meaning-making" when they reach out to non-believers. Ironically, the word "chaplain" may be easier to redefine in neutral terms than the term "Spiritual Care Professionals." This redefinition of the term chaplain has already been successfully made elsewhere, by applying the term "humanist chaplain" (*e.g.*, chaplaincy services serving university communities at Harvard and the University of Toronto[5]). I am not suggesting that hospital chaplains need to refer to themselves as humanist chaplains, rather than just chaplains. Nor am I suggesting that they need to designate individual atheist chaplains to serve the humanist chaplain role. Given the wide diversity of belief systems among patients, it makes more sense for at

least those chaplains employed in full-time hospital roles to be trained and sensitized to serve all kinds of patients.

The association that represents, organizes and trains hospital chaplains in Canada is the Canadian Association for Spiritual Care. The head of our hospital's Spiritual Care department arranged for me to take the discussion about chaplains serving secular patients to the national level by facilitating a meeting with the new President of the Association. He, too, is very interested and receptive to these suggestions and has invited me to present on this topic at their next annual national conference. I will co-present together with an atheist chaplain (one of the few) who had been trying to push for this kind of initiative for some years, but who had found the association previously not quite yet ready for this kind of change. The Association had already transformed itself over the last decade or so, from being a predominantly Christian-oriented association to being culturally inclusive and multi-faith oriented. The next logical step is for them to recognize and serve nonbelievers—specifically atheists and humanists, not just doubters, agnostics, and abstract theists.

Nudging beliefs

This work with the chaplains is arguably an application of Daniel Dennett and Linda LaScola's suggestion to help clergy to see new roles for themselves in an increasingly secular society.[6] In addition, there is a larger point to be learned through this kind of initiative. People are much more likely to shift their worldviews when they feel that they themselves are a central, active, capable, respected agent in the process of change, and maybe even seeing themselves as leading that change. Once again, it's about that feeling of control. This is a technique I use in facilitating change in psychotherapy with various kinds of patients apart from cancer patients. Many of my patients are very thoughtful and insightful. They teach me a lot. To adapt the old metaphor: when I let *them* lead *me* to the water, they are more likely to drink. I suggest to my patients that they have a better idea than I do about where to find what they are looking for. I might give them a few subtle pointers if necessary.

This approach may have a higher chance of effecting a shift in beliefs than just generating cognitive dissonance through rational argumentation, which can push people in either direction. In turn, religious chaplains have much

to teach secular humanists from their knowledge and experience. They are thoughtful, philosophical, and psychologically insightful people with a lot of experience in working with suffering people. I would advocate letting them discover that they are actually experts in existential counseling, and that they can do it just as well or perhaps even better within secular humanist frames of reference. I would prefer for them to teach us secular-humanists some things about how to help suffering people to make meaning without the God-talk, rather than us trying to convince them philosophically of the validity and viability of that approach.

Dr. Ralph Lewis is a staff psychiatrist at Sunnybrook Health Sciences Centre in Toronto, Canada, and an Assistant Professor in the Department of Psychiatry at the University of Toronto.

End Notes

1. I would like to acknowledge the invaluable role of my many patients for teaching me so much of what I have learned about the human condition, my wife for teaching me how to tolerate uncertainty with fortitude, and my many psychiatrist and chaplain colleagues (in particular) for their direct input into the writing of this article and the shaping of the initiatives described in it.
2. See, generally, http://en.wikipedia.org/wiki/Big_Five_personality_traits
3. This very common religious view is actually reflective of a certain theological paradigm. There are other more sophisticated and subtle theological paradigms, e.g., Postmodern or Constructivist, that conceptualize God as manifesting through and in our experience rather than as a separate Being intervening in the world.
4. *Waking Up: A Guide to Spirituality without Religion* (Simon & Schuster, 2014). See also http://www.samharris.org/blog/item/a-plea-for-spirituality
5. http://chaplains.harvard.edu/people/greg-epstein and http://www.uthumanist.com/p/meet-us.html. See also http://www.humanistchaplains.org/whatisit
6. http://rationalwiki.org/wiki/Clergy_Project