SPECIAL COMMUNICATION

Addressing Spiritual Concerns in Family Medicine: A Team Approach

Howard Brody, MD, PhD, Jeffrey L. Cardinal, MA, and John P. Foglio, DMin

Spiritual conflicts and concerns often accompany serious illness, but many family physicians are slow to recognize these concerns or unsure how to address them. The case of a patient with spinal cord injury and who later developed an astrocytoma is used to illustrate a team approach that involved a family physician, a spiritual counselor, and a psychologist. Narrative writing exercises in which the patient was encouraged to tell his own story also played a role in treatment. The case report includes the patient's own description of his experience with spirituality and spiritual counseling, as well as the perspectives of the spiritual counselor. (J Am Board Fam Pract 2004;17:201–6.)

Increasing attention is being paid to the spiritual dimensions of health and health care.[1,2] The need to appreciate how patients' and providers' spiritual lives are relevant to health and illness and the value of more open communication about spirituality in health are becoming widely accepted. What may not be as clear is the practical route by which spiritual issues can be addressed in the care of a patient with many complex problems.

We present a case report demonstrating the role of a spiritual counselor as an integrated member of the team caring for the patient and the benefits from explicit attention to the spiritual dimension in the care of this patient. Our report differs from most academic presentations because the patient himself (JC) is a co-author and provides a first-person account of this experience. To better represent the realities of practice, the next 3 sections of this article represent 3 different voices—first, the voice of the physician as modulated through the medical record; second, the voice of the patient; and third, the voice of the spiritual counselor. (The psychologist caring for JC was invited to contribute to the discussion also but elected not to do so.)

Submitted, revised, 4 November 2003.

From the Department of Family Practice, Michigan State University, East Lansing. Address correspondence to Howard Brody, MD, PhD, Department of Family Practice, B-100 Clinical Center, Michigan State University, East Lansing, MI 48824 (e-mail: brody@msu.edu).

Medical Case Report

JC was 35 when he first presented to HB at the Family Practice Center. At age 16, he had been struck by a car while riding a bicycle, sustaining fracture and dislocation of T3 through T5 with transverse myelitis. He also suffered from severe facial lacerations that required enucleation of the left eye and extensive repair of the forehead; a pneumothorax; and 4 broken ribs. During hospitalization lasting more than 3 months, he underwent laminectomy, tracheostomy, and insertion of a suprapubic catheter. He suffered residual ptosis of the right eyelid. Stage IV pressure sores developed that were surgically revised 6 months after initial hospitalization. He was discharged from rehabilitation with what the record described as "excellent mental status."

At the time he sought care from Family Practice, JC was working as promotions director for a local TV station and living with his wife and two adopted children. He was seeing a urologist at a referral center for ongoing bladder management. Initial care was directed at diet and exercise management of obesity related to his wheelchair confinement.

Six months later, JC was hospitalized for 12 days for urosepsis. The hospital course was complicated by emotional distress and lability, explained by the patient as being related to flashbacks to his spinal cord rehabilitation experiences. After hospital discharge, the patient continued to function well socially and emotionally, and mental health care was not initiated.

At age 37, JC left the state to take a position with university-based public radio and TV stations. He returned to the community 3 years later, at which time he was unemployed, having suffered from several health problems while out of state: phlebitis and a major depressive episode that eventually responded to management with tricyclic antidepressants. On return to the Family Practice Center, JC was noted to experience anger, irritability, and mood swings, attributed to his remaining at home while his wife now worked to support the family. He was referred to a psychologist to address these concerns and for physical therapy and physiatry. The psychologist reported that JC remained significantly depressed but recommended ongoing psychotherapy rather than medication at this time.

At age 42, JC applied for a new job and experienced increased home stress, his depression worsened, and he was placed on tricyclic antidepressants again. The psychologist reported increased expression of rage during his visits.

At age 43, JC discovered a new, major health problem. He suffered a seizure, was hospitalized, and was diagnosed with a frontal lobe tumor. On referral to a tertiary care center, a low-grade astrocytoma was diagnosed; JC was initially felt to be a poor operative candidate because of the location of the tumor. Seizures were controlled with phenytoin, and it was decided to follow the tumor with annual magnetic resonance imaging scans.

JC continued to rely heavily on the care of his psychologist for assistance in dealing with the anxiety and uncertainty of this new diagnosis. Anxiolytic agents were added to his regimen. He also expressed interest in discussing advance directives, and he eventually completed a "value history."[3]

During his 44th year, JC began to go into a deepening depression, according to his psychologist. A different tricyclic drug was tried but was later tapered because of side effects. By his 45th birthday, JC was off tricyclic antidepressants, still suffering from anxiety, and doing well in counseling. However, during the ensuing year, he became increasingly angry and frustrated. He experienced some increased facial twitching, thought possibly to be seizure activity but also possibly anxiety-related; results of an electroencephalogram were interpreted as normal. A psychiatrist was consulted who diagnosed, besides depression, post-traumatic stress disorder, panic disorder, and generalized anxiety disorder and recommended continuation of alprazolam as well as addition of an selective serotonin reuptake inhibitor.

Shortly after JC's 46th birthday, he arrived at the Family Practice Center for a routine physical examination but appeared quite distraught and tearful. He stated that he could not accept being "prodded" by a physician yet again, having recently had visits with both the psychiatrist and urologist. He expressed anger and frustration at having made so little progress despite many years of intensive psychotherapy, stating that it was extremely difficult for him to "stay in control" and to make sense of what was happening to him. After discussing a range of options, JC expressed a willingness to try writing a series of narratives to restore a sense of control and meaning in life. He was asked first to write about the present office visit and his feelings leading up to it, and to return in 2 weeks to discuss the narrative.

JC returned in 2 weeks, having not completed his narrative "homework" because of major stressors that had arisen in the interim. First, his mother-in-law underwent surgery for colon cancer and had to deal with issues around aggressiveness of future care, triggering in JC thoughts of similar issues that might arise in his own future. In addition, his urologist had found a noninvasive bladder cancer; it had been fully excised but led to the recommendation for more frequent cytoscopies for future monitoring. Despite this, JC seemed to be coping somewhat better overall.

For the first time, at this visit, JC explicitly articulated existential rather than psychological concerns. He raised questions about the meaning of life, how to face death, and other questions about mortality generally; he expressed frustrations because he could not talk to anyone about these concerns. JC (so far as HB knew) had never been active in a church and knew no clergy or pastoral counselors. He accepted a recommendation to make an appointment with a spiritual counselor in the Department of Family Practice (JF) in addition to continuing with his psychotropic medications and his psychological counseling.

JC's Own Account

Looking for my own spiritual being was always a lone search. When I was very young, my mother took my sister and me to church; my father would never go except for weddings and funerals. By the

time I was 10, we had stopped going completely. After we moved to a new community, at the age of 14, I began a search for spirituality and a church of my own. I joined a youth fellowship group and began to attend church services regularly. The church had 2 ministers who influenced me: one, dynamic, who challenged conventional wisdom and confronted my spirituality; the other a young, enthusiastic, caring minister who led youth fellowship and taught confirmation classes. Before I started going to church, I was beginning to ask the typical teenage questions: Who am I? Why am I here? Through confirmation classes, these questions began to be addressed. Having been, by family of origin, first a Lutheran and then a Methodist, I consider myself a Presbyterian because that was the church I joined as a high school freshman. After I completed confirmation classes, I joined the church, took communion, and was active in youth programs, yet I never considered myself a religious person proclaiming a faith.

As a boy, I had learned the Lord's Prayer and A Child's Prayer, "Now I Lay Me," which I repeated every night before bed as a ritual. On the night of April 30, 1965, I was pedaling my friend's bike into town with him riding in front of me on the handlebars. When the car slammed into us, my friend was thrown forward off the bike and suffered only scrapes and bruises. I was thrown back onto the grill, hood, and windshield, then off the car into a drainage ditch at the side of the road. The police at first thought that only one rider had been on the bicycle, and had it not been for me repeating the Lord's Prayer, I might not have been discovered until it was too late. I still have no idea why I was reciting that prayer then, but it must have had some meaning for me at the time.

With the accident all my thinking about philosophical and spiritual issues vaporized and my attention was focused on the present. A month afterward, I wanted to take communion, feeling I needed a reconnection with God. I also wanted to talk about the accident with my minister, but he was transferred to a distant church. No one in my family would talk about religion. My physician was a close family friend and would occasionally talk but was constrained by his busy schedule. Three months after I left the hospital, a gunman killed that physician.

Once I could drive again with hand controls, I would drive out into special, secluded places in the country and treat them as my church. I could rant and scream as well as pray, demanding of God what I had done wrong to make him so mad at me. Later, in college, I turned to humanities, psychology, and literature classes to address the great issues of the origins and meaning of life.

Although I came to know many doctors well, they never seemed to have time to talk about any spiritual issues. When I first suffered from depression in 1989, I was tortured by flashbacks of the past along with my unanswered demons. I was trying to ask spiritual questions, but these questions never came to the forefront.

I was treated with antidepressants, and my family physician (HB) suggested a course of psychological counseling. By then I had quite a lot of layers to work back through, although rage at what had happened to me was a theme running through most of the layers. Eventually, I found myself returning to many of the basic "why" questions I had asked as a teen, even before the accident. The therapist, however, was no more comfortable than my former physicians with this line of inquiry. HB also suggested that I try to write down some of my feelings in the form of essays, and that first gave me the idea and impetus to write a formal memoir.

When I first met JF, I sensed a number of things. I felt instant ease and rapport in the presence of a genuine and open person who seemed very learned but played down his learning. I sensed active listening and intelligent questioning. I learned about him as an individual, too, making it much easier to converse. I was not a lay person going for spiritual guidance but a participant in a real relationship.

My monthly (on average) sessions with JF became a different kind of psychological therapy. It seemed to lighten my mental load. I was able to focus on the broader issues in my psychotherapy and felt energized to deal with all the layers I was trying to peel back. Each of us would bring in books and articles for the other's information. My talks with JF gave me a forum to lay out thoughts that had been swirling in my mind, allowing them to take a definite shape–such as fear of abandonment and lonely death. I could address the existential thought I had read in Frankl, realizing I had looked at hospitals and the health care system as metaphors for concentration camps.[4] We also examined "Random Tragedy" and how it had affected my life, as expressed by Joseph Brodsky.[5] After I completed my memoir, JF encouraged me to ex-

pand it beyond what I had first envisioned. My writing had been an extremely important catharsis to get out the stories I needed to unburden my subconscious and to move on with life. I did this not only through my memoir but through writing short stories as well. The results were not confined to the nature of spirituality or God; rather, they encompassed a broader look at humanity and my mortality.

With JF, I could cry and repeat my questions, but most of all could finally trust someone with my most important question—what I had done to make God angry enough to do this to me? I wish I could repeat his exact words, but he eased my pain, quoted Scripture, and conveyed in words that were not bound in any doctrinal teaching that I was loved. For a long time, I had imagined that I had failed as an individual, trying to live by the teachings of a God who had no identity beyond my faith in him. Somehow I came to realize that I had been looking at both God and myself much too narrowly. I was much more than someone simply living by the rules—I could be loved for who I was independent of the rules. And maybe God was much more than an object of faith who held the power to reward or to punish. I began to see that there was more to God's being beyond the Bible and to articulate a new moral concept of myself. I had always understood the moral teachings of God but now rediscovered the concept of loving myself. I had a hard time conceptualizing loving forgiveness and putting it into practice. JF made it easier to forgive God and to understand his role in my life.

HB may have had a "medical" reason for identifying my quest as a spiritual one and referring me to JF, but I do not view the matter as medical in any way. I saw it as a chance to engage the issues about which I had always been asking with a person of unquestioned credentials and with time to devote to the inquiry. HB and JF helped me establish a trust in familiar bureaucracies and institutions of the health care system. JF was there if I needed him. HB along with my psychologist made me feel there was a network of people I could trust. But my sessions with JF, beyond satisfying some of my need for spiritual discussion, hastened the day when I was able to "graduate" from psychotherapy.

The Spiritual Counselor (JF's) Account

The role of the spiritual counselor presupposes that everyone has a spiritual component to his or her nature. I define spirituality as the practice of the values and the personal meanings of those values without which we do not thrive humanely. One cannot address a patient's suffering unless one explores those personal meanings.[6,7] I endorse Engel's biopsychosocial model as the best integrative approach to health and healing for family physicians.[8] Some have proposed adapting this model by adding another hierarchical level, to make it a bio-psycho-social-spiritual model.[9] I prefer to see spirituality as the integration of the biomedical, the psychological, and the relational, and not as an additional systemic layer imposed on Engel's model. Because we do not thrive as humans when our spiritual needs are unattended to, there is no clean distinction between spiritual care and medical care.

Spirituality and religion are not synonymous. Each person, secular or religious, recognizes and practices the values they consider "ultimate" or "supreme" in their cognitive, physical, and emotional lives. According to Bacik, secular spirituality

> involves a search for meaning in the midst of absurdity, for integration that overcomes fragmentation, for depth in a culture which fosters superficiality, for purpose in an often directionless world. In our secularized society many people participate in this spiritual search without any direct relationship to a church (religion). . . the spiritual quest in both its explicitly religious and secular version raises the most fundamental questions and plunges us to the depths of human existence.[10]

Where and how does one find a spiritual counselor? It is tempting to imagine that this is yet another purely technical specialty that can be tacked on to a health care system as needed, looking up the required professional in the Yellow Pages. I urge us to resist this temptation. The spiritual counselor is a professional striving for virtue, in the Aristotelian sense of "excellence in function." Achieving this excellence demands striving for a dual competence—competence in one's discipline and competence in one's humanity. Spiritual counselors are understanding of and conversant with the biomedical aspects of a case (but not necessarily physicians); have had training in psy-

chology (but are not necessarily licensed psychologists); and are skilled in the understanding of human relationships and able to integrate the personal meanings of values for both themselves and their patients. Family physicians must select spiritual counselors based on their personal qualities and their ability to function within a team as much as for their disciplinary knowledge.

As the spiritual counselor asked to see JC, I approached my task from the biopsychosocial framework and as a member of a 3-person professional team along with HB and the psychologist. I felt it important not to approach JC with disciplinary blinders, as if my only task was to address the spiritual parts of the "case." I needed to view myself as a *medical* professional, integrating whatever I knew of medicine along with my understanding of psychology and counseling with my specific background in religious spirituality.

My first task in meeting with JC was to establish trust and develop a working relationship, just as any physician would seek to do. JC had a story to tell us and I needed to hear it. As the story started to unfold, I identified a number of themes that seemed important. I heard about JC's attitude toward religion; his anger and depression; and his misgivings about his own abilities.

Once I had heard JC out, and he felt trust that I had truly listened to his story, I had earned the right to approach him with possible alternative meanings and interpretations. I had to be sure these were not simply my own agenda imposed on JC but alternatives that grew out of my sympathetic listening to JC's story. I could begin to suggest different ways his story might turn out in the future, beyond the ways JC himself saw his story unfolding. JC was free to reject any of my alternatives–and often did—but I kept clear between us that rejecting my alternatives was not rejecting me and that I would continue to engage with him. All members of the team felt that this was important for JC. JC's past story included important themes of abandonment, including the sudden death by violence of his family physician soon after his own accident. At times JC's open expressions of anger seemed to be a test—would we flee his anger and abandon him the same way that so many others had previously? Showing that we were all around for the long haul seemed an important objective of our team approach to treatment.

One thing I learned about myself as a result of working with JC was that I am most comfortable working as a team member. Frequently issues would come up in my discussions with JC for which my best response seemed to be, "Have you thought of talking this over with HB? With [your psychologist]?" We professionals all had to have confidence in each other and needed JC's permission to discuss among ourselves any issues that troubled one or more of us.

I believe that ultimately JC and I reached a level of equality where I could be as comfortable getting angry at him and rejecting his interpretation of events as superficial or self-serving as he could with me. With this transformation in our relationship evolved my own ability to be a voice of hope. I distinguish hope from optimism—hope is the confidence that things will make sense to us more rather than the mere wish that everything will turn out the way we want it to.

JC let me read his writings, which became quite voluminous, and that gave me even more insight into his story. I learned yet more when I met his wife and son. Eventually we seemed to reach a natural and mutual sense that our work together was largely completed. I assess this in my own way as our having gotten better in touch with what JC most valued. He seemed to become better at valuing himself as a person facing a variety of challenges, with inner strength capable of dealing with the challenges. I believe that he also became better at valuing God as an ally rather than as a punitive figure. Toward the end of our work together, I suggested my own sense that the next stage in his growth and development would lie in the direction of a greater focus on forgiveness. Here I found myself pushing up against JC's limits. He did not want to go in that direction at the time.

Discussion

JC was a complex patient experiencing a number of different but interacting health issues and crises. For a considerable time in his treatment, he seemed to be "stuck" despite having received excellent psychotherapy and appropriate pharmacologic management. Many patients in his circumstances probably suffer silently and escape our attention. Fortunately, JC was vocal in articulating his distress and facilitated a positive response.

Two interventions seemed pivotal in allowing JC to become "unstuck." First, writing has turned

into an important part of his life. Writing exercises can improve both mental and physical health.[11] It seems that the correct form of writing does much more than act as a catharsis; it helps the individual organize previously unformed experience and therefore attach meaning to it.[12,13] In this way, the narrative exercise itself (as well as the years of psychotherapy that preceded it) may have aided JC in better articulating his spiritual search for meaning.

Second, and of most interest here, JC received considerable benefit from spiritual counseling under the guidance of JF. In retrospect, one might ask why HB was so slow to discern that this intervention might be called for. One possibility is that HB was misled by JC's lack of current attachment to any religious denomination or church. The other is that JC first needed to "unpeel" many other psychological issues before he could get back in touch with his core spiritual concerns, so that a period of psychotherapy was a necessary precursor to JF's intervention.

In the end, the two interventions (narrative writing and spiritual counseling) worked in tandem, and they did so partly because the team caring for JC worked in tandem. HB, JF, and the psychologist had all collaborated in the same academic department at various times and felt comfortable working as a team. JC was an active participant in his own management and had developed sufficient trust to give consent for all team members to communicate freely about their respective roles in his care. There are no doubt many other possible models for useful spiritual work in health-related settings, but our experience highlights the special benefits of this team approach.

References

1. Foglio JP, Brody H. Religion, faith, and family medicine. J Fam Pract 1988;27:473–4.
2. Thomason C, Brody H. Inclusive spirituality. J Fam Pract 1999;48:96–7.
3. Doukas DJ, McCullough LB. The values history. The evaluation of the patient's values and advance directives. J Fam Pract 1991;32:145–53.
4. Frankl VE. From death-camp to existentialism: a psychiatrist's path to a new therapy. Boston: Beacon Press; 1959.
5. Brodsky R. Portrait of tragedy. The New Yorker 1996 Feb 12.
6. Cassell EJ. The nature of suffering and the goals of medicine. New York: Oxford University Press; 1991.
7. Kleinman A, Kleinman J. Suffering and its professional transformation: toward an ethnography of interpersonal experience. Cult Med Psychiatry 1991; 15:275–301.
8. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977;196:129–36.
9. Hiatt JF. Spirituality, medicine, and healing. South Med J 1986;79:736–43.
10. Bacik J. Spirituality in transition. Kansas City (MO): Sheed and Ward; 1996. p. 6.
11. Smyth JM, Stone AA, Hurewitz A, Kaell A. Effects of writing about stressful experiences on symptom reduction in patients with asthma and rheumatoid arthritis. JAMA 1999;281:1304–9.
12. Pennebaker JW. Writing about emotional experiences as a therapeutic process. Psychol Sci 1997;8: 162–6.
13. Brody H. Stories of sickness, 2nd ed. New York: Oxford University Press; 2003.