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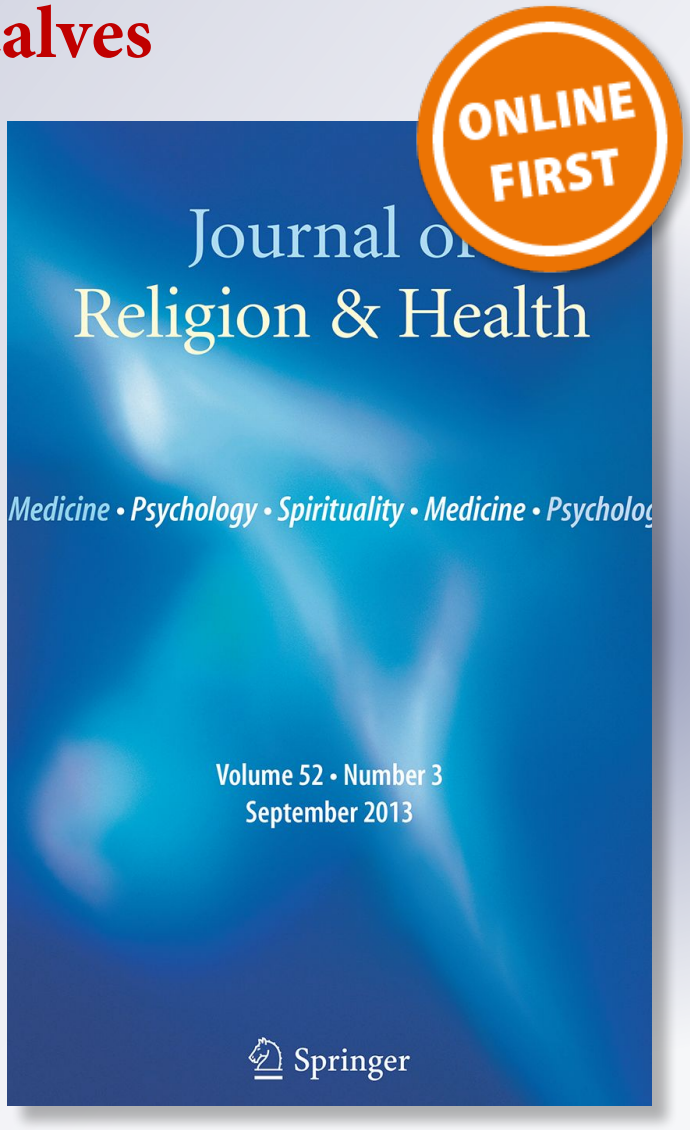

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PSYCHOLOGICAL EXPLORATION

Approaching Spirituality Using the Patient-Centered Clinical Method

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Abstract Although the scientific literature already suggests the importance of spiritual care in clinical practice, this topic has been apart from the routine of many practitioners, and many physicians still have difficulties in how to carry out such approaches in the clinical setting. This article reflects on the importance of spirituality in the health–disease process and provides an approach to the biopsychosocial–spiritual care in the practice of primary care. In addition, the aim of the authors is to propose a spiritual approach based on the patient-centered clinical method. This method has been used for clinical communication and can be powerful for exploring spiritual history. Thus, using a fictional case scenario as a practical example, the authors guide readers to understand the patient-centered approach they propose.

Keywords Spirituality · Patient-centered · Primary care · Spiritual history

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Introduction and Objectives: Which Health and Disease are We Talking About?

In daily work in primary care (PC), "simple" complaints, such as those initially presented by the character Samuel (Box 1), may hide great challenges in terms of care. The person is much more than the disease, and Samuel's problem with drinking is a common example of the importance of the doctor's interest in listening to the patient and caring for the whole person. Situations like this one require a broader view of the health–disease process and a patient-centered approach.

The consultation, in this scenario, requires the professional to learn and to think the health–disease relationship as a nonlinear process. It means that clinical reasoning must be based on a complex science. This view of complexity understands that health is affected by biological, emotional, relational, ecological, sociocultural and spiritual factors that act interdependently (Plsek and Greenhalgh 2001). It means that this view considers that there is inherent uncertainty in all particular applications of general scientific principles. In this view, the power of context, environment and personal experience will make the clinical encounter unique for both, the patient and the physician (McWhinney 1997a, b).

In this way, health care has the need to be guided by the biopsychosocial paradigm of integrality (or integral), in which it is the person in its total complexity, and not the disease, which is the focus of treatment (Anderson and Rodrigues 2016). In our perception, this paradigm can be applied in clinical practice based on the patient-centered clinical method (Larivaara et al. 2001). For this practice, it is necessary to accept the uncertainty of the process and respect the autonomy of the patient. This is especially important in the area of PC, where we take care of people, families, and communities. In this context, anamnesis becomes a key element and, therefore, must also adapt to new needs in health care.

Revising the Patient-Centered Clinical Method (PCCM)

In the midst of these many transformations, clinical practice begins to demand a balance between the objective and the subjective, an encounter between the mind and the body. It begins to be necessary to value equitably the physical, mental, social, and spiritual dimensions of the human being. These dimensions should not be seen in an isolated way, but in a complex way, in which part is not separated from the others and interact with them.

In the last 30 years, Stewart and McWhinney et al. have systematized a method that corroborates the integral approach in health: the patient-centered clinical method—PCCM (Levenstein et al. 1986; Brown et al. 1986). Initially structured in six stages, the method was reviewed and synthesized into four components that can be found in Fig. 1 (Stewart et al. 2014).

The PCCM is an example of a clinical tool that can help to promote biopsychosocial–spiritual or integral care. This methodology had its origin based on investigations that

Box 1 Starting the consultation

Preparing for his next appointment, you reviews the medical history of Samuel, a 48-year-old divorced man with untreated systemic arterial hypertension. He smokes and drinks alcohol every day. Nowadays, Samuel's main complaint is a common cold; however, you notice that he feels uncomfortable and wonders if there is anything else he would like to tell

Despite some degree of discomfort, Samuel says that the real reason for the appointment is his desire to stop drinking: "In these last three days I have not drunk and I want to take this opportunity to quit, but I have been very angry with my mother and my children. They say they prefer me drunk because I'm calmer"

indicated that the people were looking for a medical service that values the motivations for the consultation; seeks to understand their world (including emotional and existential issues); and values the physician–patient relationship, the shared decision and the prevention and the promotion of health. The spiritual dimension, for the PCCM, was considered as part of the second component, "understanding the whole person." In this article, we present a purpose of approaching spirituality applying a patient-centered communication, within all the components of the method.

Spirituality in Clinical Practice: Why to Address It?

Under the vision of the comprehensive biopsychosocial paradigm and the complexity of the health needs, it is clear that the family physician may have a better condition to stimulate adherence to treatment and behavioural changes as well as can help people in the process of re-significance of the stressing agents that cause suffering. This way, professionals may be a relevant source for promoting the development of resilience at the individual, family, and community levels.

In the perspective of integrality, the spiritual dimension must be considered as one of the factors that contribute for the health–disease process, along with the physical, psychological, and social dimensions. The evidence shows the relationship between beliefs and religious practices with better mental well-being (Koenig et al. 1998; Moreira-Almeida et al. 2014), better quality of life (Sawatzky et al. 2005), lower blood pressure levels (Gillum and Ingram 2006) and lower cardiovascular (Hummer et al. 1999) and general mortality (Chida et al. 2009) rates.

Besides that, people want their spiritual dimension to be addressed by the doctor and relate this approach to the best levels of health care (Kristeller et al. 2005). In a study with 110 Brazilian older adults, 69.5% considered the impact of their faith and beliefs on their

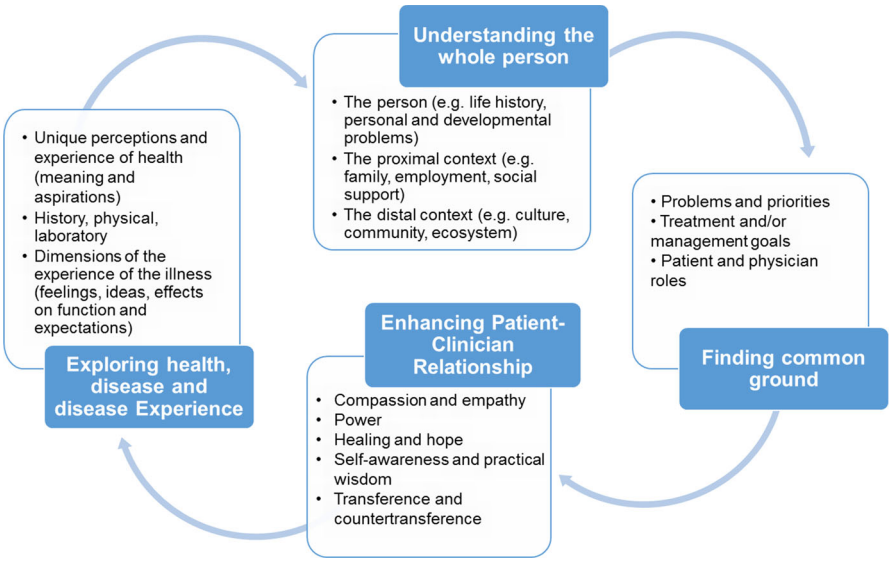

Fig. 1 Four interactive components of the patient-centered clinical method

rehabilitation to be very important and 87.3% would like their doctors to ask about their faith and religion. However, professionals had questioned only 8.2% of respondents on this topic (Lucchetti et al. 2011). Similar data found in the PC in the USA (McCord et al. 2004).

In this subject, it is important to refer to the concept of spirituality. Although there is no single concept, in this article we adopt the perspective that spirituality is a dynamic and intrinsic concept of human experience, in which the ultimate meaning, the purpose of life and transcendence is sought. In this way, spirituality pervades the relationships of the individual with themselves, their family, community, nature and what is significant, transcendent or holy (Puchalski 2014). Therefore, spirituality can be drawn not only from religion but also in art, nature, personal or scientific values (Anandarajah and Hight 2001). Thus, spirituality differs from religion, which establishes the organized or normative aspects of the creeds (Koenig et al. 2001).

The experience of the disease can lead the person into a crisis and thus mobilize thoughts about the meaning of life or the reason for suffering (Levenstein et al. 1986; Kent et al. 2015). In this way, spiritual history may support the comprehensive view of PC level, in order to assist people in their reflections on the meaning of their personal experiences as well as the development of resilience.

How to Approach Spirituality Through the Patient-Centered Practice?

In patient-centered practice, the health professional should use open-ended questions, comprehensive listening and a non-critical stance. These attitudes and skills are, in fact, real tools that can help the person, through his own narrative, to reflect on his health–disease process. Therefore, help people to revise and give a new meaning to the complex factors related to their health problem (Greenhalgh and Hurwitz 1999). Through this position, it is possible to carry out the spiritual approach using the PCCM components:

1st Component: How Does Spirituality Affect One's Sickening Process?

This component proposes that the professional seeks not only to understand the disease or clinical complaint, but also his unique experience of the human being and his health and illness. Personal religiosity can impact on the meaning that the person attributes to his illness and, therefore, through the anamnesis, the professional is able to understand better feelings, ideas, expectations and the impact of the illness.

In Samuel's example (Box 2), the patient's religiosity is an important part of his spirituality. He shows his belief in "God," but may think that "God" will not protect him anymore because alcohol abuse is against his religious principles, establishing a negative coping with the disease. On the other hand, the power of his spirituality and religiosity could be sources of support in the treatment of alcohol dependence, if they could be transformed (re-signified) into a positive coping strategy (Panzini and Flag 2007). In situations like this one, it is important for the physician to act by positively reinforcing constructive emotions or by helping to reformulate negative emotions, strengthening the therapeutic patient–physician relationship (Safran et al. 1998).

In this step, the family physician could ask about their meaningful beliefs, experiences and relationships, through direct questions such as "Where do you draw the strength to move forward?" Or, "How do you think God (or the person's belief) has helped you to

Box 2 Understanding the reasons of the patient, his context and spirituality

Surprised, but enthusiastic, with the true reason of Samuel's consultation you continue the dialogue:

"I'm really glad about your initiative, Samuel. Of course, it will not be an easy way, but our team will be here to support you. Could you tell me more about your relationship with the drink so we can think better about how we can act together?

Motivated your availability, Samuel tells you that he lived for 22 years with a woman and had 5 children with her. Eight years ago, he learned that his partner had been cheating on him for years. On the occasion, she had gone to live with the other partner and nowadays she is a drug user. The children lived with his ex-wife for 7 years, but did not agree with their lifestyle and had conflicts. For 2 years, the two youngest (Sawatzky et al. 2005; Chida et al. 2009) live with him

I imagine your struggle to face so many difficulties. But, Samuel, I also see your strength to fight. Where do you get the strength to move on?

I am a bricklayer and I like to see my work, I feel fulfilled. I also ask God a lot, but I've been a little distant from him lately

"What do you mean, distant, Samuel?"

It's because I'm a Protestant and I've been away from the church because I do not feel worthy to attend, since I'm drinking

cope with the difficult situations in your life?" These questions can act as true interventions of narrative medicine and therapeutic support.

The first step also recommends asking the patient about their health, feeling well and being able to pursue purposes and goals in life. This way, the evaluation of spiritual and existential comfort and spiritual–religious impact on the understanding of the health-disease process and well-being become parts of integral care.

2nd Component: How to Approach the Whole Person, Including Their Spirituality and Relations?

Understanding the biopsychosocial–spiritual aspects of people should be deepened in the second step. Asking about faith, beliefs, values and meaning of life is essential for clinical care be considered integral. This approach makes the narrative medicine meaningful for the person, mobilizing resources of personal resilience (Greenhalgh and Hurwitz 1999).

A significant gap between the need for integrating spirituality in clinical practice and feasible tools and protocols for its implementation can be because religious/spiritual beliefs and practices are heterogeneous among different populations and cultures (Puchalski and Romer 2000). Nevertheless, the literature has been presenting that meaning and peace (components of spiritual dimension) are more strongly associated with health outcomes than the religiosity only, and patients with high levels of intrinsic religiosity but low levels of meaning/peace have worse outcomes than those with low religiousness and high meaning/peace (Peres et al. 2017). This way, being patient-centered can help the professional to access more significant aspects of spiritual dimension of the person.

The second component also addresses the community and family dimension, inserting questions about points of conflict or social support, which can be found, for example, in cultural values, in a religious community or a significant group for the individual.

In the case shown in Box 2, the focus of spirituality developed with the question: "Where do you draw the strength to move forward?" For Samuel, religious or cultural aspect could let him apart of his belief (Example: "I've been away from the church

Table 1 Questionnaires FICA and HOPE for spiritual history

FICA questionnaire	HOPE questionnaire
F — Faith/Creed Do you consider yourself religious or spiritual? Do you have religious or spiritual beliefs that help you deal with problems? If not, what makes sense in life?	H — Hope, meaning, comfort, strength, peace, love and social relationships What are your sources of hope, strength, comfort and peace? What do the hard times hold fast? What supports and advances you?
I — Importance or influence What importance does it give to faith or religious beliefs in your life? Has faith or creed already influenced you to deal with stress or health problems? Do you have any specific belief that it can affect medical decisions about your treatment?	O — Religious organization Are you part of a religious or spiritual community? Does it help you? How? How does your religion help you and how does it help you a lot?
C — Community Do you belong to any religious group or spiritual community? Does it support you? How? Are there any groups of people you really love or who are important to you? Are communities such as churches, temples, centers, support groups important sources of support?	P — Personal and practical spirituality Do you have any spiritual beliefs that are independent of your organized religion? What aspects of your spirituality or spiritual practice do you think are most useful to your personality?
A — Treatment actions How would you like your doctor or health care professional to consider the topic of spirituality/religiosity in your treatment? Refer to any spiritual/religious leaders.	E — Effects on medical treatment and terminal problems Is your ability to do things that help you spiritually affected? As a doctor, is there anything you can do to help you reach out to the resources that normally support you? Is there any practice or restriction I should know about your medical treatment?

because I do not feel worthy of frequenting it, for drinking"), but it can be re-signified as an important aspect of his social support and his spiritual dimension ("I also ask God a lot, but I've been a little distant from him lately").

There is no single or correct way to speak of spirituality, and this does not mean, however, that this practice discards technical ability. There are many questionnaires structured to ask about the spiritual dimension of the person in PHC, such as HOPE (Anandarajah and Hight 2001) and FICA (Puchalski 2014), the latter being already validated in the literature (Lucchetti et al. 2013). These tools can be found in Table 1.

3rd Component: How to Build a Therapeutic Plan Centered on the Needs of the Whole Person?

Spiritual values can influence specific behavior, such as not wanting drug treatment or blood transfusion, but also directly influence the motivation factor (Lucchetti et al. 2010). The emotional, relational and spiritual aspects of the disease experience can be gateways to negotiate common ground and increase adherence to treatment (Stewart and Yuen 2011). The potential for a brief psychotherapeutic intervention, but also an iatrogenic action, should be considered (Box 3).

In the example of Samuel's case, the spiritual dimension was related to his ideas about himself, his self-esteem and the perception of social exclusion. From a systemic point of view, the practitioner helped Samuel reevaluate his relationship with his spiritual, religious and social dimensions by strengthening the patient support network and his personal coping strategies.

Box 3 Knowing and re-signifying the coping strategies

I understand your concern for your faith… Thank you for putting your trust in me, Samuel. Could you tell me what motivates you to stop drinking?
I would like to be an example to my children and to arrange things
Very good! And from what you told me, besides your work and children, the drink had played an important role in your life. But, as a bricklayer, you know that, for a house to stand, it needs a foundation. What is the basis on which you plan to support your life from now on?
In addition to my work and my children, I want to resume my faith in God
Yes. And how can your faith help you?
Look … I have to like it. Because, for God to help me, I need to help. I will try to seek help in the church too
Yes, we join forces, seeking support in different places

4th Component: Spirituality Can Affect the Doctor–Patient Relationship?

The professionals should be clear about their values, spirituality and personal or religious beliefs so that it would have a minor impact on their therapeutic approach. Therefore, proselytizing should be avoided and the doctor has to respect person's beliefs and values (Box 4).

For the PCCM's authors, the physician cannot attend to another person's emotions without attending to their own. The key skill would be attentive listening. To listen to a person with undivided attention is "listening not only with the ears, but with all our faculties, especially with an open heart." It would not be possible if the doctor is thinking what to say next, or if is consumed by their own negative emotions (McWhinney 1997b). This requires the professional's self-awareness to cope with frustrations, transfers or counter-transfers (Goetz et al. 2010) and the development of a deep empathetic and compassionate stance (Smith et al. 1999). This attentive state would be an "impersonal love," a love called charity (to the Greeks agape) or compassion. It is not an emotion in the usual sense and does not depend on affection, as well as it could be learned with practice and discipline (McWhinney 1997b).

In the dialogue with the patient from the example, his relationship with his children (the desire to be an example), with his work (self-realization) and with God was identified as central themes of his spiritual dimension. This initially weakened relationship was re-signified for a positive coping strategy. The integral approach of the biopsychosocial paradigm requires the professional to be able to create links, longitudinal follow-up, teamwork and coordination of care with family and community groups.

Box 4 Challenges for the therapeutic bond building

Posture, a way of looking, commitment. Because beyond the dialogue these attitudes also allowed the meeting between Samuel and his doctor was therapeutic. The perception of warmth and confidence allowed the real reason for the consultation to arise. But how does the encounter with Samuel come to his doctor? The choice between judging him unable to change or believing in his potential will penetrate the doctor's experience and will require him to mobilize his personal resilience resources to maintain this healing alliance

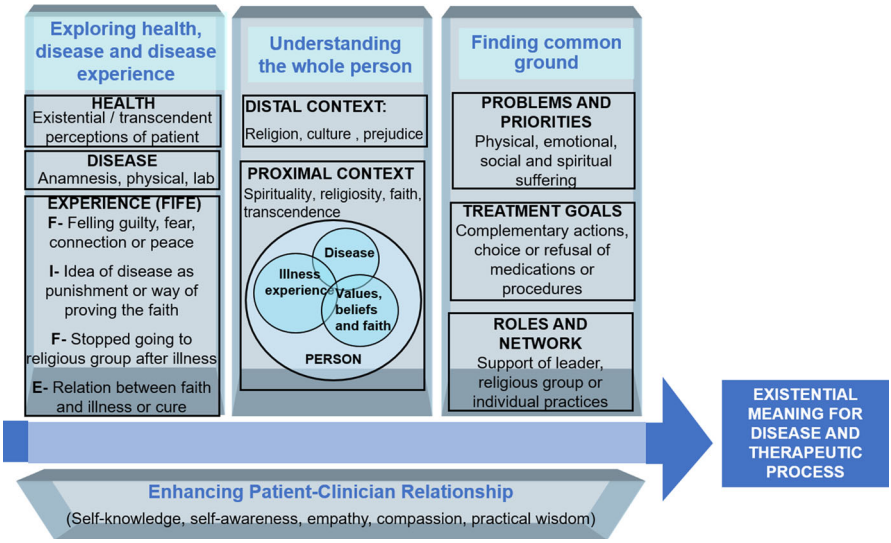

Fig. 2 Components of the patient-centered clinical method for approaching spirituality

What Conclusion Did We Reach?

Spirituality is an internal dimension of human experience and, together with biological, psychological and social factors, is at the core of the health-disease process. The patient-centered approach has made it possible to include biological and psychosocial aspects, although, in this context, spirituality remains an unappreciated dimension. The PCCM establishes possibilities of insertion of the spiritual history in each one of its components and can be useful for the use of the tools of spiritual approach in the clinical practice. This approach is summarized in the Fig. 2.

By focusing on the patient-centered approach, spiritual history may help reveal the patient's beliefs and background, be a clinical resource for comprehensive care, and to improve adherence to treatment and personal resistance of the patient. Patient-centered spiritual history has the potential to cover aspects of illness and disease and also can make the experience more meaningful for the patient and the health professional. In this way, medical intervention helps the patient to mobilize internal resources and participate in a shared decision-making process. The use of the patient-centered approach to the spiritual approach may be an appropriate strategy and an interesting perspective for further study.

Compliance with Ethical Standards

Conflict of interest None of the authors have received fees for this research or for being a speaker of a company. The authors declare that they have no conflict of interest.

Ethical Approval This article does not contain studies with human or animal participants by any of the authors.

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