

# Spirituality and Suffering Through the Four Phases of Change

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## **Abstract**

Traumatizing, life-changing events, including severe illness or war, can exert a profound effect on spirituality. The empirically validated Fennell Four Phase Treatment (FFPT™) model provides a narrative framework and cognitive map for understanding and integrating suffering resulting from these events.

The four phases – 1. Crisis, 2. Stabilization, 3. Resolution, and 4. Integration – describe a predictable passage that people navigate after significant change. Within each phase, the model addresses three domains: physical, spiritual/psychological, and social.

Many people in the Crisis phase feel spiritually abandoned. They feel at fault and that God is punishing them, or doesn't exist at all. In the first wretchedness, it's easy to believe that life is meaningless. People experience "Godlessness" and need to be responded to with comfort as they learn to allow their suffering.

When patients arrive at phase 2, they no longer feel that God is punishing them, but rather that God is absent or indifferent. People often seek the stabilizing influence of hierarchical beliefs as they learn to regard their suffering with compassion.

In phase 3, people search for meaning to validate their experiences and to find reasons for their suffering and struggle. To attempt serious investigation in Phase 1 or 2 would be premature. Phase 3 people, however, have changed. They become committed to authenticity as they construct a new self. This drive toward truth and meaning extends to their spirituality or philosophy as they learn to treat their suffering with respect.

In phase 4, people are increasingly aware of meaning on all levels of their experience. Previously, they sought answers to the big existential questions, now they seek meaning throughout their activities. They understand the search is ongoing and that authenticity is a requirement. As they learn to integrate their suffering, they commit to living with paradox in the mystery.

**Key Words:** Chronic illness, crisis, spirituality, Fennell Four Phase Model, trauma.

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## **1. Introduction**

Every aspect of society – the medical, social welfare, educational, and criminal justice systems, families, workplaces, etc. – is confronting the growing epidemic of chronic illness and trauma. Illness and trauma are irrevocably related: chronic, life-altering illness can inherently result in trauma, and emotional trauma is a risk factor for chronic illness.

Historically, suffering has been described in ideological, philosophical, or religious references and terms. Today we add the clinical and political framework of trauma. While the frameworks have expanded and changed, the intricate relationship between suffering and spiritual/philosophical development within the human condition remains.

Trauma and suffering can result from a nearly countless variety of life-changing events, including illness, war, violent crime, childhood abuse, natural disaster, incarceration, or having a close family member or friend experience any of these life-altering events. Trauma can exert a profound effect on spirituality as people try to make sense of their suffering.

The rising prevalence of chronic illness is of particular note. Due to factors including medical advances that have converted once-fatal illnesses into chronic conditions, the aging population, and the rise in conditions such as autism, asthma, and autoimmune diseases, more and more people will be living longer lives with medical conditions. In America alone, there were 129 million people with chronic conditions in 2005; this is expected to grow by 32 percent to 171 million in 2030, according to Partnership for Solutions, a research cooperative led by Johns Hopkins University.<sup>1</sup> The costs of chronic illness to the United States are huge, accounting for at least 75 percent of all health care spending, or about \$1.65 trillion of the \$2.2 trillion spent on health care in America each year.<sup>2</sup>

Worldwide, chronic conditions are responsible for 60% of the global disease burden; by 2020, 80% of the disease burden in developing countries will be tied to chronic conditions. In developing countries as few as 20% of individuals with chronic illnesses adhere to treatment protocols, placing added stress on systems of care and individuals and families. The escalating costs of chronic conditions have serious economic, social, and health-care resource consequences for governments worldwide.

## **2. Traumatization of the Suffering**

No discussion of suffering can ignore the subject of trauma. It is well recognized that experiences of chronic illness/disability, violence and crime, abuse, war, natural disaster, or other life-changing events can induce emotional trauma, manifesting in a spectrum from generalized anxiety to post-traumatic stress disorder (PTSD).<sup>3</sup> Individuals who repeatedly suffer traumas that may not meet the

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diagnostic criteria of PTSD may nonetheless experience clinical symptoms that manifest at any point on a continuum from severe PTSD to what has been called subclinical PTSD.<sup>4,5</sup>

Cumulative adversity, and the possible resulting continuum of trauma disorders, can impact the patient's ability to cope with the illness experience, the health-care system, and other life domains.<sup>6</sup> Patients may develop impeded responses to their own symptoms and the utilization of health care because of an accumulated burden of adversity. This has been investigated in certain specific medical conditions, such as heart disease and cancer, but clinically it can also be seen as a response to many chronic conditions which expose patients to various and repeated traumas.<sup>7</sup>

Current formal definitions of trauma have been criticized for excluding a variety of stress-related disorders, including prolonged and repeated trauma.<sup>8,9</sup> Current definitions may not be inclusive enough to capture what many clinicians and researchers believe to be genuine trauma experiences associated with chronic illnesses or conditions. Traumas can vary widely and individuals can suffer the effects differently. An individual's history and circumstances at the time of trauma onset can further affect the person's perception of it. Furthermore, the degree to which people may be traumatized may depend on what others think, feel, and believe about their trauma-inducing experience or illness. Some conditions naturally elicit sympathy and concern, whereas others arouse strong social condemnation and stigma.

### 3. Trauma Types

Trauma is a very real consequence of living with a chronic illness. The loss of function, livelihood, friends, and esteem conveyed by disability is deeply upsetting to individuals. Chronic illness-associated trauma can stem from several sources.<sup>10</sup>

- **Traumas caused by onset:** The person's recognition that something is very wrong can be as traumatizing as the actual effects of the illness, violence, or disaster. Additionally, the ongoing experience of chronic illness is itself traumatic and adds to the cumulative adversity. It's hardly surprising that the physical, cognitive, emotional, lifestyle, and social changes produced by chronic illness will be frightening, sad, and inevitably accompanied by loss.
- **Family response.** A person's family may not be able to adjust to the changes caused in his or her life, and their reactions can be hurtful. For

example, a spouse may be resentful that his or her partner is now unable to work or maintain previous roles and responsibilities.

- **Society’s response.** Friends, co-workers, and the society at large can be hurtful because they are afraid of a person’s disease, misunderstand it, or feel awkward around the changed person. In some cases individuals may suffer from bias fostered by the media and lose employment, housing, financial credit, friendships, even family.
- **Premorbid and comorbid traumas.** A person may have had serious traumas before becoming sick, or have other unrelated traumas which occur while ill, such as a death in the family, a natural disaster, a car accident, military service in a war zone, etc. These traumas will have an additional impact on chronic illness.
- **Introgenic traumas.** Negative treatment by health-care professionals can lead to trauma. When a person is disbelieved by a doctor or blamed for his or her suffering, a clinically caused trauma may result.
- **Vicarious trauma.** The people who live, love, and work with the suffering person can also feel trauma associated with that illness. They suffer from all of the traumas listed above. Clinicians can also suffer vicarious traumas, such as the inability to fulfill their role as healer or because they are disregarded by colleagues that don’t value the condition they are treating. Clinicians who treat patients or diseases that the society doesn’t value may suffer both professionally and financially.

#### **4. The Four Phases of Change**

The empirically validated Fennell Four Phase Treatment (FFPT™) model recognizes the influences of cultural, physical, and spiritual/philosophical/psychosocial factors in assessment and treatment.<sup>11,12,13, 14,15</sup> The multi-phased approach provides a narrative framework and cognitive map for understanding and integrating chronic illness.

**Phase 1, Crisis:** Individuals move from illness onset, which may be specifically detectable or may happen gradually, to an emergency period when it’s obvious that something is seriously wrong. The task of the individual, caregivers, and clinicians during this phase is to cope with urgency and trauma.

**Phase 2, Stabilization:** Individuals discover that they fail to return to “normal” regardless of interventions or behaviour. The task in this phase is to initiate stabilization and life restructuring.

**Phase 3, Resolution:** Individuals recognize deeply that their old life will never return. Early in this phase, most people experience profound existential despair. The task of this phase is to begin establishing an authentic new self and start developing a supportive, meaningful philosophy.

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**Phase 4, Integration:** Individuals define a new self in which illness may be an important, but not primary life factor. The goal is integration of the illness into a meaningful life.

Within each phase, the Fennell Four-Phase Model addresses three domains: physical/behavioural, spiritual/philosophical/psychosocial, and social/interactive. The experience of chronic illness does not remain the same over time; needs in the early phases of illness may differ from those several years later. Also, life changes that may be unrelated to illness may cause the individual to move backward or forward within the phases over the course of a lifetime.

#### **4. Spiritual and Philosophical Perspectives in Each Phase**

As patients move through the four phases, spirituality and philosophical perspectives evolve. This aspect of both the patient's and the clinician's mindset deals deeply with meaning and cosmology. The following section describes how spiritual and philosophical perspectives change across the four phases.

##### **A. Phase 1, Crisis**

In phase 1, the urgency and lack of control that people feel in their somatic and psychological lives may manifest in primitive spiritual or philosophical ways. Because they believe they are bad for being ill and yet cannot, in any fashion, change the facts of their situation or fix themselves, they tend to believe that God has abandoned them, that there is no God at all, or that God is punishing them. Culturally, many people in Western society carry deep fears that an angry, avenging deity may exist and that bad fortune, particularly in the form of illness, is a sign of deserved punishment. Those who believe there is no God often express deep existential despair, asserting that they have no reason to continue to live. The ambiguity of their spiritual situation mirrors the ambiguity of their clinical and social situation and causes them equal, if not greater, grief.

Clinicians may have similar feelings or worries, especially if they have not meditated on these issues in the past. Their clinical practice may also lead them to question how God can permit the suffering they see daily. Clinicians may also experience countertransference in response to the philosophical role that patients often trust them with or thrust upon them; patients may regard clinicians as the arbiter of philosophical or spiritual meaning, and this responsibility may be more than the clinicians can bear.

Because people in phase 1 are beset by the immediate problems of their crisis, they are usually unable to do any deep or meaningful work. In phase 1, clinicians should seek only to provide a generalized sense of philosophical and spiritual comfort. They need to react compassionately to patients' expressions of fear and self-condemnatory statements, and suggest that there are alternative

ways to view the situation and confirm that meaning will exist in the future. Until patients progress into a later phase and can engage in more sophisticated philosophical meaning development, clinicians mainly act as comforting, empathetic, witnessing presences to this aspect of the person's experience.

### **B. Phase 2, Stabilization**

People in phase 2, like in phase 1, believe that the locus of power concerning their lives and, especially, their illness resides outside themselves. For those who believe in God, their relationship to God mirrors their relationship to their illness. Phase 1 patients regard God either as altogether absent or as actively punishing them with pain and illness because they are – or have been – bad in some way. In the greater containment of phase 2, patients no longer feel that God is punishing them precisely, but rather as though God has turned attention elsewhere.

Phase 2 draws many back into the practice of their religion, often the religion of their youth, especially if their religion's institution is highly structured and hierarchical. Many clear, invariant rules and rituals help contain the world for people, whose lives have been overturned. It also alleviates the painful, burdensome issues of ambiguity. Phase 2 patients, who often feel less symptomatic than those in phase 1, may believe they will regain their former health if they perform rituals sincerely, properly, and for a sufficient amount of time. Their plateau experience can convince them that God will eventually reward their complaint behaviour.

Phase 2 is also a time of seeking, including new, more satisfactory spiritual or philosophical connections. New critical faculties may make people reject the God of their past, who was willing to subject them to gratuitous pain and suffering. Patients, seeking unambiguous rules and emotional containment, may turn to spiritual settings that offer firm, hierarchical structure.

Patients may also be influenced spiritually by new friends with similar conditions. People who are empathetic and compassionate to a patient's suffering, and who are emotionally supported by active religious practice, may influence the patient to join that congregation and/or faith.

Where the patient's spiritual life does not hurt the patient or others, it is usually best for clinicians to passively support whatever course the patients choose. Highly structured religious settings may aid clinicians in the work of containing patients' nearly boundless world.

### **C. Phase 3, Resolution**

In phase 3, patients need to engage in a search for meaning to validate their existence in the universe and find reasons for their suffering and struggle. They need to find (or approach) some explanation for what has happened, even though that explanation may be that things are random and without any divine –

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or other – intention.<sup>16</sup> They also need to generate a genuine sense of purpose – not simply a trite, hackneyed expression ascribed to those society regards as damaged – that he or she can sincerely and personally commit to.

Because phase 3 patients have ceased to pretend or try to make themselves fit into what they perceive as society's demands, they become committed to truth and authenticity as they try to construct their new self. Inevitably, this drive for truth extends to their spirituality or philosophy. Where the tenets of their religion or beliefs seem inauthentic or inadequate for their new self, they look to new resources, including traditions outside their cultural norms.

Clinicians can be helpful in the patient's search for authentic meaning. They can expose patients to new cultural, philosophical, or religious traditions which may provide a new angle of vision on the essential questions of human existence. Nonverbal experiences, such as music or art, can help build significant meaning for some individuals. Clinicians can suggest patients discuss matters of meaning with their minister or other spiritual advisor, study philosophy or religious texts that delve into meaning and purpose, or converse with friends who are interested in similar issues.

While respecting the wisdom of spiritual tradition, phase 3 patients gain responsibility for determining the truth and meaningfulness of spiritual and philosophical ideas within themselves. They recognize that they must live according to what they know to be true and possible for themselves and according to the beliefs that they deeply, genuinely, and personally commit to.

### **C. Phase 4, Integration**

Phase 4 patients are increasingly aware of meaning on all levels of their existence. Whereas in phase 3, they sought answers to their personal existential questions, in phase 4 they seek meaning in all their activities. Here, the practical value of an activity is less relevant than the activity's overall place and meaning. They understand the search is ongoing and that authenticity is a requirement.

As they learn to integrate their suffering, they commit to living with paradox in the mystery. This heightened awareness makes patients demand more of everything they do. They may have to live with limitations, but they can insist that whatever they do be meaningful.

The search for meaning continues, as time and life events constantly shake up perceptions that once seemed sure and clear. While their questions will probably never be answered, there is satisfaction in pursuing the process and experiencing moments of illumination. Clinicians' role in phase 4 is to support patients as they integrate suffering as a meaningful part of their lives.

## **5. Conclusion**

The Fennell Four-Phase Model is a validated framework for explaining how people who are experiencing chronic illness, trauma, and suffering can adapt to the changes in their lives. As people move through the four phases, their perception and understanding of spirituality evolves as well.

The goal of the FFPT approach is not pursuing the ever-elusive cure, rather it is integrating illness and suffering into the patient's life. FFPT helps patients, clinicians and families organize a narrative framework and cognitive map for understanding and integrating suffering resulting from these events.

### Notes

- <sup>1</sup> Maureen Glabman, '12 DM Trends you Should Know About,' *Managed Care*, 14 (2005), Viewed 25 January 2012, <<http://www.managedcaremag.com/archives/0508/0508.twelvedmtrends.html>>.
- <sup>2</sup> Micah Hartman, Anne Martin, Patricia McDonnell, Aaron Catlin and the National Health Expenditure Accounts Team, 'National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998,' *Health Affairs*, 28 (2009): 246-261.
- <sup>3</sup> Ronald C. Kessler, Amanda Sonnega, Evelyn Bromet, Michael Hughes, and Christopher B. Nelson, 'Posttraumatic Stress Disorder in the National Comorbidity Survey,' *Archives of General Psychiatry*, 52 (1995): 1048-60. PMID 7492257.
- <sup>4</sup> Arthur S. Blank, 'The Longitudinal Course of Posttraumatic Stress Disorders,' in *Posttraumatic Stress Disorder: DSM-IV and Beyond*, ed. Jonathan R.T. Davidson and Edna B. Foa (Washington, D.C.: American Psychiatric Press, 1993), 3-22.
- <sup>5</sup> Scott Vrana, and Dean Lauterbach, 'Prevalence of Traumatic Events and Post-Traumatic Psychological Symptoms in a Nonclinical Sample of College Students,' *Journal of Traumatic Stress*, 7 (1994): 289-302.
- <sup>6</sup> Angelo A. Alonzo, 'The Experience of Chronic Illness and Posttraumatic Stress Disorder: The Consequences of Cumulative Adversity,' *Social Science and Medicine*, 50 (2000): 1475-1484.
- <sup>7</sup> Angelo A. Alonzo, and Nancy R. Reynolds, 'Emotions and Care-Seeking During Acute Myocardial Infarction: A Model for Intervention,' *International Journal of Sociology and Social Policy*, 16 (1996): 97-122.
- <sup>8</sup> Lewis Herman, 'Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma,' *Essential Papers on Post Traumatic Stress Disorder*, ed. Mardi J. Horowitz (New York: New York University Press, 1999), 82-98.
- <sup>9</sup> Gillian Mezey, and Ian Robbins, 'Usefulness and Validity of Posttraumatic Stress Disorder as a Psychiatric Category,' *British Medical Journal*, 323 (2001): 561-563.



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- <sup>10</sup> Patricia A. Fennell, *Managing Chronic Illness: Using the Four-Phase Treatment Approach*, (Hoboken, N.J.: John A. Wiley & Sons, 2003).
- <sup>11</sup> Patricia A. Fennell and Lucinda Bateman, 'Matching Best Medical Practices to Phases of Illness,' Lecture: IACFS Conference, Salt Lake City, Utah, October 9, 2004.
- <sup>12</sup> Patricia A. Fennell, Leonard A. Jason, and Susan Klein, 'Measuring Phases of Recovery in Patients with CFS,' *Journal of Chronic Fatigue Syndrome*, 5 (1999): 88-89.
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- <sup>14</sup> Leonard A. Jason, Patricia A. Fennell, Renee R. Taylor, Guy Fricano, and Jane Halpert, 'An Empirical Verification of the Fennell Phases of the CFS Illness,' *Journal of Chronic Fatigue Syndrome*, 6 (2000): 47-56.
- <sup>15</sup> Leonard A. Jason, Patricia A. Fennell, Susan Klein, Guy Fricano, and Jane Halpert, 'An Investigation of the Different Phases of the CFS Illness,' *Journal of Chronic Fatigue Syndrome*, 5 (1999): 35-54.
- <sup>16</sup> Victoria Schirm, 'Quality of Life,' in *Chronic Illness: Impact and Interventions*, ed. Ilene Lubkin and Pamala Larsen (Sudbury, MA: Jones and Bartlett, 2002), 191-201.

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## Author Biography

**Patricia A. Fennell** is a researcher, clinician and author specializing in chronic illness, trauma, forensics, hospice, global health care concerns, and the validated Fennell Four Phase Treatment model. President and CEO of Albany Health Management Associates, she is regularly invited to lecture to, advise, and consult with government, professional, medical, academic, management and patient organizations in North America, Europe, and Africa. Her books include *Managing Chronic Illness: The Four Phase Treatment Approach* and *The Chronic Illness Workbook*. Patricia is a jazz vocalist. In 2009 she recorded her first CD, *Frim Fram Sauce*.