

## Spiritualité, religion et douleur

Anita M. Unruh

Les rapports entre spiritualité et santé occupent une place de plus en plus importante en recherche, y compris dans le domaine des sciences infirmières. Peu de travaux de recherche ont porté sur la spiritualité, la religion et la douleur jusqu'ici, même si, tout au long de l'histoire, certaines croyances spirituelles ont été empreintes de notions relatives à la souffrance. Ces croyances peuvent avoir un effet sensible sur la façon dont un patient perçoit la douleur et sur les décisions qu'il prendra relativement à sa gestion. L'auteure propose une synthèse de la recherche sur ces questions dans une perspective historique. Elle analyse en quoi la spiritualité et la religion ont servi à construire une idée de la souffrance qui se reflète sur la perception de la douleur, l'adaptation à celle-ci et sa gestion. Cette approche comporte des implications cliniques, notamment en ce qui concerne les points suivants : la communication entre soignant et patient sur les questions liées à la spiritualité et à la douleur; l'intégration de ce thème dans les programmes d'éducation et d'aide; le respect des préférences spirituelles en matière de gestion de la douleur, là où cela est possible et justifié; la consultation avec les équipes de conseillers spirituels; la réflexion que mène l'infirmière sur la place qu'occupe la spiritualité dans sa propre vie. L'article se termine sur une discussion des implications pour la recherche.

Mots clés : spiritualité, religion, douleur

# **Spirituality, Religion, and Pain**

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Understanding the relationships between spirituality and health has become increasingly important in health research, including nursing research. Very little of the research thus far has focused on spirituality, religion, and pain even though spiritual views have been intertwined with beliefs about pain and suffering throughout history. Spiritual views can have a substantial impact on patients' understanding of pain and decisions about pain management. The author reviews the research literature on spirituality and pain from a historical perspective. The analysis is concerned with how spirituality and religion have been used to construct a meaning of pain that shapes appraisal, coping, and pain management. The clinical implications include respectful communication with patients about spirituality and pain, inclusion of spirituality in education and support programs, integration of spiritual preferences in pain management where feasible and appropriate, consultation with pastoral care teams, and reflection by nurses about spirituality in their own lives. A discussion of research implications is included.

Keywords: Spirituality, religion, pain

## **Introduction**

Considerable progress has been made since the publication of Melzack and Wall's (1965) effort to reframe pain from a biomedical to a more comprehensive biopsychosocial perspective. There is a substantial body of research examining the interactions between physiological and psychological mechanisms of pain (for a review, see Fields, Basbaum, & Heinricher, 2006). More recently, attention has also been given to understanding the social context of pain, including ethnic and cultural issues (e.g., Craig & Riddell, 2003). Nevertheless, very little attention has been focused on the impact of spirituality and religion on patients' pain experience, despite a growing concern in the health literature with spirituality and health.

Increased interest in spirituality and health is related to researcher and practitioner interest in how people construct meaning when faced with serious life issues (Clarke, 2006). Koenig, McCullough, and Larsen (2001) propose three additional reasons for this interest in spirituality and health. First, despite the increased secularization of society, spirituality and religion continue to play a role in the daily lives of many people. Second, populations are rapidly aging and consuming more health care with its

associated costs, leading to greater concern with the factors that promote health and resilience. Third, traditional biomedical models of practice have brought significant challenges for health professionals who are more comfortable with technological care and patients who seek more humane, compassionate care. This tension between traditional health care and the preferences of patients has resulted in increased opportunities for alternative and complementary therapies, in part because many of these therapies incorporate a spiritual framework.

Spirituality and religion have a significant bearing on patients' beliefs about pain, strategies for coping with pain, and approaches to pain management. Often, these beliefs are unknown to health professionals because spiritual issues are perceived as personal and private (Koenig et al., 2001). Although interest in spirituality and pain is relatively recent in terms of pain research, spirituality and pain have historically been intertwined, since the causes of pain are often elusive and persistent pain may lead to suffering. Pain and suffering are not interchangeable terms. Suffering is the perception of serious threat or injury to the self that emerges when there is a discrepancy between what one expects of oneself and what one does or what one is (Chapman & Gavrin, 1999). This discrepancy in the construction of self-identity is associated with loss and grief, which may be experienced as suffering (Unruh, 2004). Suffering can lead one to wonder about the meaning and purpose of one's life. For a person living with chronic pain, suffering may occur as a result of the pain, but it may also occur for other reasons or may not occur at all. In this paper I will examine the spiritual and religious meanings associated with pain — and suffering when it concerns pain — with an emphasis on Christianity as the dominant religion in Western countries. Next I will address the spiritual or religious tensions that can arise for the patient experiencing pain, and then conclude by focusing on practical considerations for clinicians and researchers.

### **Distinction between Spirituality and Religion**

Although there is no generally accepted definition of spirituality in the health literature, there are common themes in proposed definitions, as illustrated in recent reviews (Chiu, Emblen, Van Hofwegen, Sawatzky, & Meyerhoff, 2004; Tanyi, 2002; Unruh, Versnel, & Kerr, 2002). Spirituality is often defined as the experience of transcendence, connectedness, meaning, and purpose in life, integrating aspects of the self or a search for the sacred. These definitions reflect a construction of spirituality that is individualistic and not necessarily associated with traditional religion. Such secularization of spirituality reflects a growing tendency in Western societies to retain some aspects of religiosity, such as transcendence, while

rejecting the institutional and doctrinal aspects of organized religion (Hill et al., 1998; Tanyi). Religion is usually used to convey a set of beliefs and practices around the existence of something sacred or divine such as God, a higher power, or an ultimate truth (Koenig et al., 2001). Neither spirituality nor religion has received much attention in pain research even though spiritual views have for centuries been intertwined with beliefs about pain and suffering (Unruh, 1992). Although early biblical writings suggest that religion might provide comfort and solace to those living with pain and suffering (Koenig, 2003), in ancient religions, and in Christianity until relatively recent times, pain was regarded primarily as a consequence of sin and misfortune or as a human condition that could be mastered to achieve a higher spiritual state.

### **Historical Perspectives on Spirituality, Religion, and Pain**

Most if not all ancient civilizations believed that pain and disease were caused, sustained, and cured by supernatural entities. Spiritual leaders were believed to be the only people capable of carrying out divine will through medicine (Castiglioni, 1975). Treatment consisted of appealing to the gods through incantation, religious ritual, sacrificial offering, prayer, or exorcism (Castiglioni). Although there was a greater understanding about the physiology of pain and disease among the ancient Greek and Arabian physicians of the Middle Ages, the early Christian Church exerted a strong influence on the management of pain and disease. Physicians had little power since all cures were believed to be miraculous and there were religious proscriptions against some pain-relieving drugs (Todd, 1985). Monastic medicine, with its reliance on drugs, surgery, spells, incantation, prayer, exorcism, and relics, prevailed (Haggard, 1929; MacKinney, 1937). For example, a physician's handbook written in the year 1000 BCE includes a recipe for Holy Salve, a wound dressing made by combining butter with 60 different herbs while reciting spiritual incantations, following which the following prayer was said over the salve:

Holy Lord, Omnipotent Father, Eternal God: by the laying on of my hands may the enemy, the Devil, depart from the hairs, from the head, from the eyes, from the nose, from the lips, from the tongue, from the undertongue, from the neck, from the breast, from the feet, from the heels, from the whole framework of his members, so that the Devil may have no power over him, neither in his speech nor in his silence, neither in his sleeping nor in his waking, neither by day or by night, neither in resting nor in running, neither in seeing nor in sleeping, neither in writing or in reading; So be it in the Name of the Lord Jesus Christ, Who redeemed us with His Holy Blood, Who liveth with the Father and Reigneth God, world without end. Amen. (Cartwright, 1977, p. 12)

According to Kinsley (1996), the linking of pain, suffering, and disease with sin and divine punishment and visitation was at times so strong that physicians were instructed not to treat patients who did not first confess their sins to a priest. In 1215 the Church declared that because sickness was caused by sin the physician's first duty was to summon a priest (Fourth Lateran Council). In the 16th century physicians had to swear that they would stop treating a patient if, after 3 days, he or she had not made a confession (Kelsey, 1973), and in the 18th century Catholic physicians were forbidden to practise medicine if they treated patients who had not confessed.

In the 19th century this tension between medical advances and religious beliefs was manifested in the suspicion surrounding the development of anesthesia. Both the medical literature and the popular press featured heated debate about the benefits and drawbacks of pain and painlessness (Glucklich, 2001; Pernick, 1985). There were threats that babies delivered through painless childbirth would be refused the sacrament of Baptism (Glucklich). There were arguments that pain was necessary for healing, that pain was God's will, that pain was spiritually uplifting (Fulop-Miller, 1938; Gardner, 1987). To eliminate pain was to do the work of the devil. This was the view held by William Atkinson, the first president of the American Dental Association:

I think anesthesia is of the devil, and I cannot give my sanction to any Satanic influence which deprives a man of the capacity to recognize the law! I wish there was no such thing as anesthesia! I do not think men should be prevented from passing through what God intended them to endure. (Quoted in Raper, 1945, p. 105)

Aside from religious objections, there were concerns that ether and chloroform were intoxicants and should be rejected on moral grounds (Glucklich, 2001). Anesthetics were thought to mask symptoms and thus to subvert the natural healing process (Porter, 1852) and possibly the life force needed to give birth during labour (Smith, 1847). These drugs were believed to compromise medical ethics by reducing the patient's autonomy (Pernick, 1985). They were costly and exacerbated problems associated with discrimination and prejudice (Glucklich). These issues were intertwined with religious objections to the use of anesthetics.

Caton (1985) and Sauerbruch and Wenke (1963) argue that it was the eventual acceptance of anesthetics that fundamentally shifted attitudes towards a secular view of pain. They conclude that the ability to alleviate pain resulted in an unwillingness to adapt to and live with pain, which in turn increased feelings of helplessness in situations where pain could not be relieved.

The view that pain and suffering were sent by God nevertheless persisted. In 1940, C. S. Lewis, author of *The Chronicles of Narnia* among other works, wrote:

Until the evil man finds evil unmistakably present in his existence in the form of pain he is enclosed in illusion. Once pain has roused him he knows that he is in some way or other “up against” the real universe; he either rebels with the possibility of a clearer issue and deeper repentance at some later stage, or else makes some attempt at an adjustment, which, if pursued, will lead him to religion... No doubt pain as God’s megaphone is a terrible instrument; it may lead to final and unwanted rebellion. But it gives the only opportunity the bad man can have for amendment. (Lewis, 1940, p. 83)

Lewis’s views were not very different from other Christian perspectives of the period. The Office for the Visitation in the *U.S. Book of Common Prayer* (Anglican), 1928 to 1978, also expresses the view that pain and sickness are sent by God to teach a lesson, to punish, or to correct sinful ways:

Wherefore, whatsoever your sickness is, know you certainly that it is God’s visitation...to try your patience for the example of others...or else be sent unto you to correct and amend in you whatsoever doth offend the eyes of your heavenly father... (<http://justus.anglican.org>)

But these views were changing. The 1979 *U.S. Book of Common Prayer* is concerned not with pain as an instructive spiritual experience but with comforting the person in pain through religion. It includes the following prayer for the person experiencing pain:

Lord Jesus Christ, by your patience in suffering you hallowed earthly pain and gave us the example of obedience to your Father’s will: Be near me in my time of weakness and pain; sustain me by your grace, that my strength and courage may not fail; heal me according to your will; and help me always to believe that what happens to me here is of little account if you hold me in eternal life, my Lord and my God. Amen. ([http://justus.anglican.org/resources/bcp/formatatted\\_1979.htm](http://justus.anglican.org/resources/bcp/formatatted_1979.htm))

Another spiritually influenced perspective is that pain can be experienced as transcendental, mystical, or religious. Throughout history there have been religious devotees (e.g., monks, nuns, mystics) who have sought out pain as a means of hurting the body for the sake of the soul, a form of what Glucklich (2001) refers to as sacred pain. Enduring pain in the physical world is thought to ensure salvation, bringing the sufferer closer to the suffering of Christ or some other spiritual leader. Pain enables the person to reach a higher plane of spiritual or religious experience, as illustrated by the comment of a religious pilgrim quoted by

Glücklich: “At one moment everything is pain. But at the next moment everything is love. Everything is love for the Lord” (p. 38). According to Brena (1972), “religion teaches that the human individuality is not fulfilled until God-communion is realized, when the ontological unity with our Creator is experienced as an expanded sense of awareness, love and supernatural joy” (p. 131). Brena argues that prayer behaviours, which are central to all religious doctrines, are opposite to pain behaviours, because they break down feelings of isolation and focus the individual on love and service to others. Brena (1978) expresses the view that it is ultimately possible to go beyond pain, to reach a mystical union with a divine being — that indeed pain makes this possible. Brena’s writings are strongly influenced by his own Christian convictions.

Other writers argue that pain that is transformed into a spiritual experience is no longer pain but something else. For example, Scarry (1985), in an interview with Geddes (2000), maintains that pain is always negative and that to put a religious construction on the experience of pain would be counter-intuitive:

If I will myself into a situation of pain such as a medical therapy, and I agree to go to a doctor and let her do something to me that hurts (or seek out pain for religious reasons), then it’s already very different. And it’s not just different as an interpretative act, but, rather, to say that more clearly, the act of interpretation is so deeply grounded in the felt experience itself that if I am actually seeking it, it already has a kind of power to transform the pain. That is, it is no longer pain, since pain is centrally the experience of aversiveness. (<http://www.virginia.edu/iasc//hh/THRtoc2-2.html>)

Pain that is sought out is likely to be physiologically, psychologically, and spiritually different from pain that is experienced involuntarily as is the case in most instances of acute or chronic pain. Although science, medicine, and the secularization of spirituality have changed the ways in which people regard their pain, there is increasing evidence showing that spirituality and religion are important to how people experience their pain and suffering (Bartlett, Piedmont, Bilderback, Matsumoto, & Bathon, 2003; McCaffrey, Eisenberg, Legedza, Davis, & Phillips, 2004; Rippentrop, 2005; Rippentrop, Altmaier, Chen, Found, & Keffala, 2005).

### **Religion and the Meaning of Pain**

Very little is known about how 21st-century patients use their spiritual or religious views in constructing the meaning of their pain. Koenig, a nurse and psychiatrist specializing in chronic pain, lives with chronic pain himself and self-identifies as a Christian. In his book on spiritual

approaches to chronic pain, Koenig (2003) quotes some of his Christian chronic pain patients:

I feel like God doesn't put any more on you than you can bear... The Lord picks you for this because you can take it. He doesn't give you more than you can handle. (pp. 79, 83)

It's given me the ability, not only the ability but the desire, to see God in a different way than I would if the pain wasn't there. (p. 94)

... it's like the Lord is telling me, "This is a burden that you're going to have to carry. I carried the cross and your sin, and you're going to have to carry this." (p. 46)

Although these views are Christian, their underlying meaning may not be unique to Christianity. Thomas (1992), in a study with Hindu religious renunciates, found similar health attitudes and behaviours among his respondents. The most dramatic attitude was one of classic detachment and separation from pain. When asked what he did for his pain, one renunciate replied:

Think that you are different from the pain. If a tree in front of you is being cut, you are just the observer. You know that the body is going to perish. So whenever you are ill bear it by your knowledge that you do not belong to this particular body. You have renounced it. (p. 501)

Other Hindu respondents expressed an acceptance of pain as the will of God, similar to the Christian view expressed in Koenig's (2003) work: "Whatever God wants to give, He can give me. He can do anything according to his desire. Human desire can't do anything" (p. 501). They also saw in pain a similar opportunity for spiritual growth:

Suffering is necessary. When you have this suffering, you begin to feel deeper. Each moment of pain or suffering enables you to understand what it means when others suffer from it. This wideness of consciousness is a very important thing. (p. 501)

Käppeli (2000) also found fewer differences than might be expected in the religious meaning that Christian and Jewish cancer patients gave to their suffering, despite the differences in the structures underlying their religion. The patients explained their suffering in stories of retribution and a return to a better life, stories of wrestling with God, apocalyptic stories in which their experience was part of the disintegration of the world and the coming of the Messiah, and stories of mystical transfiguration. In the three monotheistic religions, Islam, Judaism, and Christianity, pain and suffering are linked with perceptions about the nature of humankind; pain is a punishment for the flawed nature of humankind and a means to improve one's nature (Koenig et al., 2001).



Koenig et al. (2001) suggest that the difference with Christianity is that pain as punishment is seen as relievable through atonement and redemption. Further, the image of a crucified Messiah who understands pain and suffering may provide guidance and comfort in one's living a meaningful life with chronic pain (Koenig, 2003, 2004). Despite some similarities among religions, there may be considerable differences between and within spiritual perspectives and religions. Such differences are not well understood with respect to how they shape a conceptualization of pain (Low, 1997). There has been little comparative research in this area.

### **Religion and Coping**

There is a significant body of research examining the influence of spirituality and religion on mental health concerns, physical health issues, and addiction (Koenig et al., 2001). Much of this research has focused on prayer and coping (e.g., McCaffrey et al., 2004), but attendance at religious services has a stronger association with positive health outcomes than prayer (Koenig et al., 2001).

There is a small body of research on spirituality and religion and coping with pain (Conway 1985/86; Koenig, 2002). These studies have begun to identify the potential positive and negative associations of spirituality and religion with pain. For example, Bush et al. (1999) examined positive and negative religious coping and non-religious cognitive-behavioural coping in 61 chronic pain patients. They found that positive religious coping was significantly associated with positive affect and religious outcomes (spiritual growth, satisfaction with religious life, relationship to God). They found no association between negative religious coping and other study outcomes. Harrison et al. (2005), in a sample of 50 African-American patients with sickle cell disease, found that church attendance (weekly or more often) was associated with lower pain measures. This outcome is similar to the results of an earlier study by Yates, Chalmers, St. James, Follansbee, and McKegney (1981), in which having religious beliefs was found to be positively associated with measures of well-being and less pain in patients with advanced cancer. Rippentrop et al. (2005), in a study with 122 patients with chronic musculoskeletal pain, report that patients with poorer physical health engaged in more private religious behaviours such as prayer, reading religious material, and meditation, perhaps to cope with more serious health problems. Spirituality and religion were found not to be related to pain intensity or interference of pain in daily life. Patients in this sample were also more likely to report feeling abandoned by God than participants in a sample without chronic pain. In a prospective study with people with rheumatoid arthritis, Keefe et al. (2001) found that partici-

pants reported much more frequent use of positive rather than negative spiritual coping strategies. Individuals with frequent daily spiritual experiences had more positive mood and higher levels of social support. The findings were similar in another sample of patients with rheumatoid arthritis (Bartlett et al., 2003) and in a sample of nursing home residents (Koenig, Weiner, Peterson, Meador, & Keefe, 1998). Cronan, Kaplan, Posner, Lumberg and Kozin (1989), in an earlier study with arthritis patients, found that prayer was the most common unconventional coping strategy, 54% reporting it to be very helpful. These studies suggest that, for patients living with pain for whom spirituality is a part of daily life, spirituality is important to successful coping.

Integral to coping with persistent pain or living with pain may be the ability to accept pain. Risdon, Eccleston, Crombez, and McCracken (2003) examined the meaning of acceptance of chronic pain and found that for some participants spiritual strength was an important aspect of acceptance. Participants who had a spiritual view of acceptance saw living with pain day-to-day as based not on personal or motivational strength but on spiritual strength. They endorsed such statements as “I can identify with myself on a spiritual level,” “God has been telling me to change,” and “I have been rewarded for all the suffering I have gone through in the past.” Koenig (2003) suggests that a spiritual attitude towards pain, based on submission, acceptance, understanding, and calling, enables a person with religious views to live a meaningful life with chronic pain. He conceptualizes “submission” as having submitted one’s life to God, “acceptance” as having turned pain over to God and not worrying about it, “understanding” as believing that positive emotions are possible despite pain, and “calling” as serving God and others.

An issue related to spirituality, religion, and pain is the impact of these views on patients’ preferences with respect to pain management.

### **Religion and the Management of Pain**

Religious views may influence a person’s acceptance of various pain-management approaches and her or his treatment goals. Koenig (2003) lists four misconceptions about pain management that might be held by patients with strong religious views:

- 1) reluctance or refusal to take pain medication (or to take sufficient medication) because of addiction fears; 2) belief that pain should be dealt with only in spiritual terms, and taking medication for pain relief would be relying on something other than God; 3) belief that pain should not be relieved because pain may result in spiritual growth; and 4) persistent pain may be regarded as a sign that the patient’s faith is not strong enough. (p. 3)

Such misconceptions can have a significant impact on patients' use of medications for pain, especially persistent pain, pain associated with disease, or pain during palliative care (Bosch & Banos, 2002). Refusal of pain medication may also be associated with a desire to feel closer to the suffering of a spiritual leader, as is the case with some Christian patients. The Catholic Church allows the use of medication to relieve pain even if it may hasten death, but, as elaborated by O'Rourke (1992), the Church also maintains that to voluntarily endure pain in the last stage of life is to share in the suffering of Christ and to prepare for death:

Suffering, especially suffering during the last moments of life, has a special place in God's saving plan: it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which he offered in obedience to the Father's will. Medication, coma, reduce opportunity to share or experience in this way. Nevertheless, the church recognized the ideal cannot be a general rule...would be imprudent to impose a heroic way as a general rule... If possible, a person should have the opportunity "to moderate the use of pain killers, in order to accept voluntarily at least part of their sufferings and thus associate themselves in a conscious way with the suffering of Christ." (p. 488)

Koenig (2003) suggests that religious views may also affect the acceptability of management strategies such as relaxation, hypnosis, guided imagery, and mindfulness meditation, if these strategies are seen as possibly inconsistent with the patient's spiritual beliefs. Such strategies may be perceived as a kind of New Age spirituality and therefore potentially unacceptable to a religious person. The literature contains no empirical research on the extent to which spiritual or religious views influence patients' use of pharmacological strategies or their preferences with respect to non-pharmacological interventions such as cognitive-behavioural therapies.

Spiritual beliefs, attitudes about pain, and decisions with respect to pain management may seem contradictory as the patient endeavours to reconcile beliefs, needs, and treatment options. For example, Thomas (1992) found that even though the attitudes of Hindu renunciates suggested that pain should be borne rather than relieved, all but one renunciate did use some type of medical relief for pain. The men struggled to reconcile their pursuit of medical care with their beliefs, especially among the most conservative group. For example, they justified seeking relief for severe pain. They also accepted pain relief if it would be more injurious not to treat pain than to treat it in order to help others. The most conservative participant saw the active pursuit of treatment as a violation of his vows of renunciation. Only if a physician said to him, "Take it for my sake" would he agree to do so, and then only traditional medicine and not allopathic or Western medicine. In Judaism and Islam,

pain relief is acceptable because pain may impair quality of life and proper functioning (Bowker, 1978; Koenig et al., 2001). In Christianity, Islam, and Judaism, pain relief near the end of life may cause concern should it risk causing death but is acceptable if unrelieved pain is likely to hasten death (Puchalski & O'Donnell, 2005).

Refusal of pain medication and other management approaches due to religious beliefs can be a source of stress for health professionals, especially nurses and physicians (Kumaska & Miles, 1996). Referral to and consultation with a pastoral care team or other spiritual counsellors, if desired by the patient, is recommended (Koenig, 2003). Open discussion with the patient and her or his family about spiritual views and how they can be incorporated into the management plan will likely be beneficial for both the patient and the team. Patients with spiritual or religious views about pain may also need to examine and possibly challenge their beliefs with the assistance of a trusted health professional, in order to determine which pain-management strategies are acceptable given the person's spiritual worldview.

Another issue that has not been widely examined in pain research is whether spiritual practices can be incorporated into pain management and whether this would have a positive effect on the patient's care.

### ***Spiritual Approaches***

Spiritual approaches to pain management can take many forms, from prayer, to participation in religious services and rituals, to therapeutic touch, spiritual healing, mindfulness meditation, Reiki, and other strategies. Some of these strategies are explicitly religious, whereas others take a more secular spiritual approach. In some cases the strategy will have roots in religious tradition but will have been modified to make it more amenable to a diverse group of people. For example, mindfulness meditation has roots in Buddhism but is typically used in Western culture separately from its traditions within Buddhism (Baer, 2003).

Research on the effectiveness of most spiritual therapies is inconclusive and is complicated by the many different approaches to spiritual therapy and the situations in which they are used. Nevertheless, reviews of this research indicate that while the evidence is not definitive, positive outcomes are possible. Roberts, Ahmed, and Hall (2003) conducted a Cochrane review of the effectiveness of prayer as a complementary intervention for those with health problems being treated with standard medical care. They report that the data were too inconclusive to guide those wishing to uphold or refute the effect of intercessory prayer on health-care outcomes (achievement of desired goals, death, illness, quality of life or well-being) but that the findings thus far do justify further study. Astin, Harkness, and Ernst (2000) reviewed randomized clinical

trials of interventions using some form of “distant healing” (e.g., therapeutic touch, Reiki, prayer, spiritual healing) and report that 57% of trials found some positive benefit.

Many spiritually based therapies have not been examined in the context of chronic pain. Abbott et al. (2001) examined healing approaches in a sample of 100 chronic pain patients whose pain was resistant to conventional treatments. The primary outcome measure was the total pain rating index score on the McGill Pain Questionnaire (Melzack & Katz, 1992). The study was a randomized clinical trial comparing face-to-face healing or simulated healing and distant healing or no healing in a series of weekly 30-minute sessions over 8 weeks. Healing was defined as direct interaction between a healer and a patient for the purpose of improving or curing the condition (Hodges & Scofield, 1995). The therapeutic benefit was thought to result from the channelling of energy from source via the healer to the person to promote self-healing (Fulder, 1996). The authors conclude that no specific effect could be demonstrated. Mindfulness meditation is essentially a secular spiritual application of meditation and has been used in pain management following initial work by Kabat-Zinn (1982). There is growing evidence of the effectiveness of mindfulness meditation for some patients with chronic pain (e.g., Wachholtz & Pargament, 2005; Weissbecker, Salmon, Studts, Dedert, & Sephton, 2002).

### **Clinical Implications**

There are a number of surveys reporting that patients want their health-care providers to consider their spiritual or religious preferences when offering services (e.g., Daaleman, Cobb, & Frey, 2001; Daaleman & Nease, 1994). It is unclear how these preferences should be taken into consideration, however, especially within the parameters of responsibility specific to a profession. Florin, Ehrenberg, and Ehnfors (2005) found that when nurses and patients in an acute-care setting were asked to identify which problems were most important to patients, the nurses often missed the patients’ emotional and spiritual concerns. There are important ethical considerations for professionals and patients in addressing spirituality. Sensitivity and respect for patients’ spiritual needs is likely to be beneficial, but harm is possible if discussion causes health professionals to defend or assert a particular religious perspective (Unruh et al., 2002). Benefits are much more likely to result if the patient’s spiritual views, whether secular, sacred, or religious, are respected rather than ignored or challenged and if care can be provided in such a way that the patient’s spiritual needs are not violated. A person-centred approach is key to

ensuring that the patient's spirituality is understood from her or his perspective.

Embarking on a discussion about spirituality can be intimidating. Health professionals who are comfortable with their own spiritual journeys may be more willing than others to engage in spiritual discussions about pain with their patients (Unruh et al., 2002). Brockopp et al. (1998), in a discussion about barriers to good pain management, argue that the spiritual views of physicians and nurses may affect their beliefs about the pain management of their patients. For this reason, it may be useful for nurses to reflect on their own spiritual beliefs and values and what they mean to the nurse-patient relationship and to the nurse's beliefs about pain management.

There are many instruments available to measure spirituality or religion (Tanyi, 2002; Unruh, Versnel, & Kerr, 2003). These may be used to initiate discussion about spirituality. It is essential that health professionals first consider what information about the patient's spirituality would be helpful and how it can be used within the parameters of professional responsibilities. One way to begin is to ask the patient about what she or he finds meaningful or important in life and whether her or his spiritual views have relevance for these issues. It may be helpful to ensure that the patient has access to spiritual counsellors as well as to a pastoral care team. It may also be beneficial to discuss with the patient and family how their spiritual practices can be incorporated into the care provided by the medical team. Newshan (1998) and Tanyi discuss some of the ways in which nurses can incorporate spirituality into their care, emphasizing awareness of the nurse's own spiritual views, discussion and acceptance of the patient's perspectives, and the importance of a compassionate therapeutic relationship. Such discussion may be particularly critical if the patient is in acute pain, refuses pain medication, or is receiving palliative care. Inclusion of questions about spiritual needs and preferences in intake assessment will ensure that this area is not forgotten.

The Canadian Pain Society's 1997 *Position Statement on Pain Relief* ([www.canadianpainsociety.ca/policy.html](http://www.canadianpainsociety.ca/policy.html)) asserts that patients have the right to the best pain relief available and that unrelieved acute pain complicates recovery. For some patients, the best pain relief will be that which is consistent with their spiritual or religious views. Some patients may choose to rely partly or wholly on their religious views to manage pain. Engaging in dialogue with patients about their spiritual and religious views with respect to pain is a good beginning; recognizing that these views may influence preferences and decisions about treatment will have clinical implications. Patients stand to benefit from pain education that not only examines the interrelationships between physiological and psychological mechanisms of pain and pain management but also

considers the ways in which their spiritual and religious views can affect their ability to manage their pain and to live a meaningful life with pain. Consideration of positive and negative aspects of religious coping in education/support programs may help patients to use their spiritual and religious views in ways that will enhance their pain-management strategies. Patients may need to be shown that they are better able to serve others as part of their spiritual or religious commitments when their pain is well managed using pharmacological, psychological, and spiritual approaches. It may also be possible to integrate some of the patient's spiritual or religious views with other therapies. Music can be deeply meaningful to patients across secular, spiritual, or religious perspectives (e.g., Krout, 2001; Magill, 2001). Relaxation interventions and guided imagery can incorporate spiritual or religious music, readings, or images that are meaningful to the patient. Patients may have spiritual readings, prayers, or music that can be recorded and played to assist with pain management. A patient may be open to having a nurse recite prayers or readings with her or him, especially if patient and nurse share a particular spiritual view. If spiritual counsellors from diverse backgrounds are available, patients will have an opportunity to speak with respected individuals who share similar beliefs and staff will have ready access to a rich resource.

These clinical implications suggest avenues for nurses to examine how spirituality and religion may be addressed in pain care. However, the potential benefits of these implications need to be examined more closely in pain research.

### **Research Directions**

Many efforts have been made to define spirituality and religion in ways that provide more clarity for research in this area, but there are no agreed-upon definitions. Agreement would enable comparison of findings across studies. Much of the epidemiological research on spirituality, religion, and health, including pain, is correlational in nature and provides limited information about causal relationships between spirituality and pain outcomes. Prospective studies are needed, to examine how spirituality and religion influence coping and adjustment to pain and whether such influences differ among diverse spiritual and religious views. It is important to determine whether the positive and negative aspects of spiritual coping bear out for most patients and whether they remain consistent across different spiritual perspectives. It is essential to determine the extent to which spiritual and religious views about pain influence the acceptability of pharmacological and non-pharmacological pain interventions. Underreporting of pain and non-compliance with

interventions may be related to the incompatibility of interventions with spiritual or religious beliefs or misunderstandings about their mutual benefits for pain management. It is not known whether or how the integration of spiritual views into acute or chronic pain management leads to better outcomes. Further research is also needed to determine whether the influence of spiritual or religious views on appraisal of pain, pain coping, and preferences in pain management is related to patient gender, age, ethnic group, or socio-economic class.

Although it is evident that spirituality and religion influenced conceptualizations about pain and suffering in the past, little is known about how various spiritual and religious beliefs influence appraisal of pain and pain management in the modern era, or how these beliefs might be communicated by families or within spiritual communities. There has been no research on what patients with pain want from pain professionals with respect to spiritual issues, and no research on what might be the best strategies for ensuring that spiritual needs are met in pain clinics. Lastly, spiritual needs are often heightened in palliative care, but there is limited research on how spiritual views about pain affect pain-management preferences in palliative care. Nurses have a critical role to play in developing knowledge in this area, because they are intimately involved in the immediate pain and suffering of their patients.

### **Conclusion**

Spirituality is often seen as a private and subjective area that lies outside of the therapeutic context, but patients' beliefs can have a substantial, if hidden, impact on construction of the meaning of pain, coping behaviour, and preferences in pain management. Patient surveys have indicated that patients want their health-care providers to ask about their spiritual beliefs and to show sensitivity with respect to how these beliefs might affect their health needs. There are many opportunities to integrate spirituality and religion into clinical practice. Much more research in the area of spirituality and pain is needed, to examine the impact of diverse spiritual and religious views on patients' appraisal of and coping with pain, their beliefs about pain management, and their preferences.

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