Religious Orientation and Pain Management

Jaclyn Faglie Low

Key Words: coping • internal-external control • professional-patient relations

Occupational therapists may find pain management less effective than anticipated for the patient’s condition. In exploring additional avenues of relief, it is important to look beyond physical agents. The therapist must sort physical, psychological, and spiritual components of pain to provide appropriate intervention or referral.

The interface between health care and religion is strongest at the point of confrontation with a life-changing event. Literature addressing the relationship between religious orientation and pain perception differentiates among major religions but not among differences in beliefs of diverse denominational groups. Understanding beliefs about pain may be indispensable to its effective management.

Productivity demands necessitate sensitivity to factors other than the physical in order to avoid ineffective treatment. The patient’s beliefs can be explored within the contexts of initial evaluation and the course of treatment. Knowledge of the mechanics of pain and treatment modalities can be augmented by awareness of the influence of beliefs on response to treatment.

Occupational therapists use a variety of pain-relief techniques. These may include electric stimulation, ultrasound, thermal agents, massage, specific inhibition or facilitation techniques, and instruction in relaxation techniques. Although these are often effective, some patients may not respond as anticipated, leaving both patient and therapist frustrated and bewildered. In exploring additional avenues of relief, it is important to look beyond physical agents. In referring to the fears of persons with terminal or life-threatening illness, Schuetz (1995) said, “When physical symptoms are not controlled by usual means one needs to consider whether emotional issues such as fear of death are impacting upon the expression of the physical symptom” (p. 775). Fear of loss of a familiar way of living because of chronic pain and disability can have an equally strong impact.

The interface between health care and religion is at no time more apparent in a person’s life than when he or she is confronted with the end of life as it is known. Although a person may not have been active with an organized religious group or displayed a dominant spiritual orientation during preillness life, a resurgence or intensification of religious affiliation may occur. Richard Lamerton (1973), a pioneer in the hospice movement, noted:

We have built ourselves a fortress of personality and have thought of ourselves only as a body which we feed, pamper, and adorn and display with all our energy. When the body is spoiled and the fortress crumbles, we are compelled to search for something more permanent than either. (p. 88)

When therapists are sensitive to the possibility that factors other than or in addition to physical components of pain are interfering with the success of treatment, they have questions about what to do next. Clearly, referral to other resources such as social workers, psychologists, or spiritual counselors may be in order. However, many patient needs can be met within the context of occupational therapy. Schuetz (1995) identified patient needs that can be addressed by all health care providers:

- To feel supported
- To feel free to discuss their feelings about their disease
- To have their feelings, especially fear, understood
- To understand the feelings of significant others
- To have information of how the disease will affect their life
- To have information regarding the medical aspects of their disease
- To know there will be ongoing care. (p. 776)

To provide support and a climate open to discussion of feelings and fears, the occupational therapist needs to

Jaclyn Faglie Low, PhD, OTR, is Associate Professor and Chair ad Interim, Department of Occupational Therapy, School of Allied Health Sciences, The University of Texas, 301 University Boulevard, Galveston, Texas 77555-1028.

This article was accepted for publication November 22, 1996.
understand as fully as possible the beliefs the patient brings to the interaction. Although addressing physicians, Dunphy’s (1978) counsel is important for occupational therapists and other health care providers: “If we understand how patients view themselves and their diseases, we will be much better doctors” (p. 11). He recommended that “all practicing physicians should acquire at least a sympathetic understanding of the major religions of the world” (p. 11).

To explicate their statement, “Beliefs therefore are precursors to behavior and can influence motivation to engage in future actions,” Williams, Robinson, and Geisser (1994), noted: “While knowledge of a person’s beliefs cannot perfectly predict future behavior, assessing sufferer’s beliefs can provide insight into how one understands what they are experiencing and what needs to be done to remedy the experience” (p. 77).

Pain and Suffering

For many centuries, it has been recognized that pain is more than a physiological phenomenon. Aristotle suggested that pain is also an emotion, as much a part of human experience as anger, joy, and terror (as cited in Bresler, 1979). Koff (1980) noted, “Depression and anxiety lower the individual’s threshold to perceive pain and may actually increase the need for a pain-relieving drug” (p. 46). Tu (1980) observed that “pain as a human experience involves a complex interaction of physical, mental, and spiritual processes” (p. 65). Each of these citations speaks not of pain itself, but rather of the suffering associated with pain. Pain and suffering are not the same, although they are frequently associated and the terms are often used interchangeably. Pain is a physiological phenomenon with neuroanatomical or physiological theories to account for its occurrence. Suffering, as described by Cassell (1995), is “a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity” (p. 1899). Suffering in the absence of physical pain is a common human occurrence, often associated with emotional states such as loneliness or despair. Pain, especially chronic or that from unknown causes, is a source of suffering, so it is actually the suffering associated with pain that health care professionals attempt to alleviate.

Meanings of Pain

Jensen, Turner, Romano, and Lawler’s (1994) research into the relationships between individual beliefs about pain and adjustment to chronic pain indicate a correlation between the two. Although this study did not examine the origins of beliefs about pain, through comparing responses on a survey of attitudes about pain with subjective reports of pain, the authors established, “What patients believe about their condition predicts functioning” (p. 306). Respondents with strong beliefs that emotions affect pain and that pain results in disability were found to have greater indication of psychosocial dysfunction, whereas those who had strong belief that pain denotes damage had higher incidence of physical dysfunction.

In offering theological perspectives on suffering, Cassell (1995) described five categories of beliefs:

- Suffering as a result of human sin.
- Suffering as educational and evidentiary.
- Suffering as sacrificial and leading to some greater good.
- Suffering resulting from the forces of evil or chaos.
- Suffering as mysterious or meaningless. (p. 1903)

Bowker (1978) noted that religions are concerned about the successful outcome of human life and offer guidelines for ways to understand problems of existence, among them pain. They differ in explanation of the nature of pain and in ways of dealing with pain because they differ in their views of the nature of man. In Judaism, pain and suffering are a part of the fate of mankind, a given. The sufferer may consider that his or her pain results from sin or that it serves to atone for sin. However, it is not necessary to seek out pain for atonement and it is appropriate to combat pain even though it may be serving the purposes described.

Generally speaking, pain and its reason for occurrence are considered to be a mystery. The human mind cannot fathom the intention of the deity. In Islam, pain may be punishment for sin and error, and it may be a means of instruction and learning. Humans are responsible for using God’s instructions to act in the right way. It is all right to resist or fight pain because although it may serve the purpose noted, it ultimately does not belong in God’s paradise (Bowker, 1978).

The Christian view is that guidance and instruction are not enough to reform human behavior. Jesus’s sacrifice of pain and suffering is necessary because radical change was needed to overcome the deficiencies of human nature. Pain, suffering, and death may be punishment for serious fault, but the penalty can be removed through atonement and redemption, both of which involve pain and suffering. The philosophy of asceticism, of suffering for greater good, is a part of some Christian perspectives. Suffering is seen as a constructive force for personal growth (Bowker, 1978).

In comparing perspectives on pain, Tu (1980) noted that although the role of pain in strengthening and purification is common to Christian, Buddhist, and Confucian beliefs, in the Christian faith, pain is the result of Original Sin and thus indicative of human fallibility and a form of
retributive punishment. According to Tu, the Buddhist sees pain as a part of all the passages of human life, a defining characteristic of human life, and thus an experience to be endured in a matter-of-fact manner, whereas the Confucian may view pain as a trial but also believe that a cure for it is both desirable and necessary for one's own well-being.

Pompey (1984) offered an explanation from a Christian viewpoint that suffering and pain, along with every other tribulation of human life, occurs as a result of disordered or disturbed relationships. The original disturbance of relationship occurred between God and man. Serious illness and pain can be linked to disturbed relationships between mind and body, the spiritual, physical, and psychological self. Englehardt (1980) described the 

Christian account of suffering or redemption in which the man-God is portrayed as accepting great suffering in order to buy back man from sin and perdition. Christians are then, within this view, enjoined to bear pain and suffering because of the positive effect of such endurance in the economy of salvation. (p. 463)

Shaffer (1978) explored the notion of pain as an illusion brought on by false beliefs and bad thinking. This is voiced in both Hinduism and Christian Science. To intervene in pain, the Christian Scientist concentrates on God and the good in the world and on the nonexistence of pain and suffering. The Hindu works to gain understanding that the world is an illusion and to attain detachment from that illusion.

Denominational Differences

Literature that speaks to the relationship between religious orientation and pain perception is, for the most part, directed at differentiating among major religious groups such as Christians, Jews, Buddhists, and Hindus. Only Shaffer (1978) mentioned a specific denominational group, Christian Science. This presents a problem for the person who is attempting to appreciate differences in beliefs about pain among diverse denominational groups that make up the overall classification of Christians. Rosten (1975) listed 79 denominations, many of them Christian, in the United States. Many of these have subdenominations. For example, there are three different Adventist groups and 21 different Baptist groups. It hardly seems possible that these numerous groups share any more of a belief about pain than they do about other topics.

Neither Rosten’s (1975) Religions in America nor Mead and Hill’s (1985) Handbook of Denominations in the United States described differences in belief systems with regard to pain. However, other differences among Christian denominations provide insight into the possibilities of differences in this area. One of the most important is how the Bible is regarded. The King James version, according to the concordance of The Scofield Reference Bible (Scofield, 1947), has five specific references to the word pain, and three of these speak to a relationship between pain and death (Ps. 116:3, Acts 2:24, Rev. 21:4). According to Mead and Hill (1985), denominational differences are many.

The Episcopal Church considers the Bible sacred for its general inspiration and does not hold to literal inerrancy. Baptists believe the Bible to be infallible for religious teachings but are divided as to its overall inerraility. Unitarians consider the Bible to be a “library” of books by different authors, all of which are subject to interpretation in the light of current knowledge and some of which are more valuable than others. Seventh-Day Adventists believe that the original authors of the Bible were inspired by God and that the original message has survived through subsequent translations, and, therefore, the teachings of the Bible should be taken literally (Mead & Hill, 1985). In light of these differences, consider the potential for differences in interpretation of the Bible passages noted and in the interpretation of individual pain.

Analyses of other differences in belief further illustrate the error of lumping many groups together under the heading of a “Christian viewpoint.” The ritual of baptism is an excellent example. Disciples of Christ baptize only those who are old enough to understand the implications of confessing Christ as savior (Mead & Hill, 1985). They baptize by immersion to symbolize death, burial, and resurrection as well as total obedience. Rosten (1975) compared Quakers (or the Religious Society of Friends), who do not practice any form of baptism, with Methodists, who practice infant baptism and believe that the original message has survived through subsequent translations, and, therefore, the teachings of the Bible should be taken literally (Mead & Hill, 1985). In light of these differences, consider the potential for differences in interpretation of the Bible passages noted and in the interpretation of individual pain.

The articulation of pain entails self-description which, in turn, reveals attitudes, belief and
world-view” (p. 67). It can be safely said that the opposite holds true: that articulation about belief and worldview gives information about perceptions of pain with respect to both its experience and its meaning.

However, the patient may not be able to verbalize his or her current beliefs or those that are brought forward from childhood. Although the inability to articulate clearly a belief system does not in any way diminish its importance, attempting to analyze a person’s worldview on the basis of either verbalized beliefs or observation and interpretation of cultural values is difficult. There is always the possibility that the health care provider’s interpretations will be influenced by personal orientation. The occupational therapist is faced with the dilemma of sorting out the physical, psychological, and spiritual components of the patient’s pain to provide the appropriate intervention or referral. According to Williams et al. (1994), “Beliefs are probably best judged not by how true or false they are but by how adaptive they are in enabling the believer to function in the world he/she experiences” (p. 71).

The impact of one patient’s religious beliefs on pain and pain control was illustrated in a case report by Heiligman, LaMont, and Kramer (1983). They related the situation of a 68-year-old black woman who, after surgery for resection of carcinoma, was noted to have made no requests for medication for relief of pain. Careful evaluation revealed that the patient was not denying the presence of pain but, in fact, was exhibiting a relaxed and comfortable demeanor. When questioned by physicians, the patient revealed that she had been under the care of angels since childhood. Although she had been cognizant of the presence of angels, surgery before her “knowing the Lord” (p. 300) had necessitated postoperative analgesia. Psychiatric evaluation revealed no evidence of emotional or mental disorder.

By way of explanation for this phenomenon, Heiligman et al. (1983) listed five predictors for severity of pain: (a) increased expectation of pain, (b) increased anxiety about recovery, (c) increased anxiety as a basic personality trait, (d) increased vigilance as coping behavior, and (e) increased internal locus of control. They extrapolated these findings to suggest that the opposite of each factor might serve as a predictor of decreased pain. The authors believed that the patient had little expectation of pain and little anxiety about recovery because of previous uneventful surgeries. The presence of watchful angels since childhood minimized anxiety and the need for vigilance, and the angels were believed to serve as a completely externalized locus of control. In the final paragraph of the report, the authors commented on the lack of attention to the study of the influence of religious belief on pain response and noted that “unless the physician solicits the patient’s perception and interpretation of events, he may never realize the existence of such well-developed and vivid support systems” (p. 302). However, there is no indication in the body of the article that as much attention was given to the patient’s religious beliefs as was given to laboratory studies and psychiatric evaluation.

Lynn (1993) described a case equally affected by religious beliefs but with a very different outcome. A middle-aged woman with extensive open lesions from breast cancer required twice daily dressing changes that were excruciatingly painful. She consistently refused offers of pain relief. Witnessing the pain inflicted by their care was a source of suffering for staff members. Careful questioning revealed that the patient’s beliefs were based on her affiliation with the Salvation Army. The use of alcohol or narcotics in any form was abhorrent to her. Even more important was her belief that suffering on earth emulated that of Christ’s at the Crucifixion and was preparation for her afterlife. Thus, as Lynn pointed out:

Within her tradition and understanding, her choice was the only one that made sense. Once she shared it with us...we were able to endure with her and to honor her commitments. Doing so was not easy, but doing so without understanding was almost impossible. (p. 44)

A concern that needs to be addressed in appreciating the importance of a patient’s religious orientation is that of regression. It is generally accepted that people tend to regress to earlier levels of development with the stress of serious illness or pain. Regression may be manifested by increased dependence. However, regression may be apparent in other ways. Examination of Kohlberg’s (1968) six stages of moral reasoning reveals that reliance on an external source of control is a feature of early childhood. If we concur with Heiligman et al. (1983) that the patient described in the preceding example was functioning under a system of external control in the form of protective angels, it seems that regression in this case had a positive benefit in terms of pain control. The possibility exists, however, that a shift in levels of moral reasoning could, in another patient, result in distress. For example, a Unitarian patient who believes that conduct and ideas about right and wrong are matters of individual conscience (Chworosky & Raible, 1975) may, with the stress of illness and pain, return to an orientation of external control and a fundamentalist upbringing of punishment and reward. Such a patient’s pain might be interpreted as punishment for real or imagined sin, and, if the punishment is perceived as deserved, response to pain-relief measures may be compromised. The health care provider may need to explore with the patient not only current beliefs, but also beliefs from childhood.

Clinical Application
In this era of fast-paced schedules and limited patient visits, it is ludicrous to recommend interactions with the
patient that demand the luxury of extended time. However, sensitivity to factors other than the physical may prevent ineffective or prolonged treatment. There are ways that the occupational therapist can, within the time allotted for physical treatment, address spiritual needs as well.

Fulton and Moore (1995) incorporated into the nursing process steps for assessing spiritual needs. As part of the assessment, they included observing the environment for the presence of religious articles and use of religious rituals. In planning treatment, the health care provider should “be aware of needs related to specific religions” (p. 229). Elsdon (1995) advocated a direct approach, using a spiritual history guide to ask such questions as, “Do you feel your faith/religion is helpful to you? Has being ill changed your belief about this?” (p. 642).

None of these activities are exclusive to nursing. Each can be incorporated into initial and ongoing occupational therapy evaluation. Just as the occupational therapist asks the patient about how activities of daily living in the areas of dressing, grooming, and homemaking are affected by illness or disability, so should the question be asked about the exercise of religious observances. Information gained about specific practices can guide open-ended questions about beliefs, both present and past.

Conclusion

To achieve effective management of pain, it is necessary to appreciate that the phenomena of pain and suffering are a complex combination of physical, emotional, and spiritual factors. Knowledge of the mechanics of pain and of the efficacy of a variety of treatment modalities is important but does not address the entire issue. Beliefs that the person brings to an illness and pain experience, whether current or those of childhood, influence personal interpretation and response to treatment.

References


