

Spirituality and Pain: Emerging Evidence and Coping

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Disclosure

- Nothing to disclose.
- Cannot identify any potential conflict of interest.
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Learning Objectives

- To understand current knowledge about the influence of spirituality on individuals with chronic pain.
- To discuss current issues related to spirituality that are frequently encountered in clinical practice during treatment of chronic pain.
- To discuss models of coping with chronic pain that includes spirituality.

Spirituality

- “Whatever or whoever gives ultimate meaning and purpose in one’s life that invites particular ways of being in the world towards others, oneself, and the universe.”
- (Wright, 2004)

Unruh (2004)

- “Despite the secular trend in the worldview of many people in Western countries, spirituality and religion do matter to many people who experience pain, especially when pain is persistent... People struggle to make sense of their pain experience in ways that can be traced well back into ancient history.”

Unruh (2004)

- “People who struggle with their spiritual and religious views and their understanding about pain are at risk for inadequate pain management.”

Rosner (2001)

- *(Archives of Internal Medicine, 161)*
- Historically, religion and healing were inseparable.
- Physician and priest often the same person
- Separation of the mind and body has corresponded with a separation of medicine and religion.
- Spiritual and religious practices are increasingly been viewed as a form of complementary therapy.

Rosner (2001)

- Why?
- Discouragement and despair
- Fear, adverse effects, previous negative experiences with medical tx.
- Increasing focus on ‘whole person’ approach including physical mental and spiritual

Rosner (2001)

- Why?
- May improve ability to cope with stress.
- May have analgesic properties.
- May inoculate to some extent against depression and suicide.
- Adds social / psychological support.

Rosner (2001)

- Why?
- May decrease negative / risky behaviours.
- Meaning
- Existential coherence
- Community integration

Muller et al. (2001)

- *What the research shows:*
- Most persons have a spiritual life
- Most patients want their spiritual needs assessed and addressed
- Supporting a patient's spirituality may enhance coping and recovery from illness

Rosenweig (2004)

- *Religious involvement, spirituality, and health:*
- 18 prospective studies: + survival
- Decreased cardiovascular disease
- Lower blood pressure
- Decreased anxiety, depression, substance abuse
- Improved HRQOL
- Improved health coping
- Less anxiety at end-of-life

Muller et al. (2001)

- *What the research does not show:*
- Religious people don't get sick
- Illness is due to lack of religious faith
- Spirituality is the most important health factor
- Health care providers should prescribe religious activities

McCord et al. (2004)

- *(Annals of Family Medicine, 2)*
- Studied appropriate situations, reasons, and expectations regarding spirituality and religion in medical setting
- 921 respondents
- 83% wanted physicians to ask about spiritual beliefs in at least some circumstances

McCord et al. (2004)

- Most acceptable scenarios for discussing spirituality included:
 - Life threatening illness (77%)
 - Serious medical conditions (74%)
 - Loss of loved ones (70%)

McCord et al. (2004)

- Among those who wanted to discuss spirituality, the most important reason for this discussion was desire for physician – patient understanding.

McCord et al. (2004)

- Patients reported that this discussion would affect physicians' ability to:
 - Encourage realistic hope (67%)
 - Give medical advice (66%)
 - Change medical treatment (62%)

Bagiella et al. (2005)

- (*International Journal of Epidemiology*, 34)
- Points to methodological flaws in early research
- Recent studies with improved methodology suggested reduced mortality in some populations
- 14 456 participants in National Institute of Aging-funded research

Bagiella et al. (2005)

- After controlling for variety of factors, frequent religious attendance associated with increased survival in entire cohort
- However, stratified analysis showed that this association only existed for two of four research sites.

Everyday Practice

- **Benefits**
- Hope
- Acceptance
- Meditation
- Purpose
- Service
- **Barriers**
- Medication
- Relaxation wariness
- Putting self first

Negative Spirituality

- Guilt – This is a punishment for something I have done.
- Alienation – Why have I been abandoned by God?
- Anger – This is God's fault.
- (Rosenweig, 2004)

Barriers

- “...many health care providers are uncomfortable teaching patient groups about spiritual care for fear of offending them.” (Rutledge, 2004)

Personal experience

- Patients bringing up spirituality
- Importance of rapport in treatment

Bush et al. (1999)

- Role of religious and nonreligious cognitive-behavioral coping in 61 chronic pain patients
- Participants described their chronic pain and indicated their use of religious and nonreligious cognitive-behavioral coping strategies.
- Results supported multidimensional conceptualization of religious coping that includes both positive and negative strategies.

Bush et al. (1999)

- Positive religious coping strategies associated with positive affect after controlling for demographic variables.
- Negative religious coping strategies not associated with outcome variables.
- Several significant associations found between nonreligious cognitive-behavioural coping strategies and outcome variables.

Dunn & Horgas (2000)

- 50 community-dwelling elders
- 96% of elders used prayer to cope with stress
- The most frequently reported alternative treatment modality was prayer (84%).
- Number of spiritual treatment modalities significantly correlated with use of more positive coping styles.

Keefe et al. (2001)

- Role of daily spiritual experiences and daily religious/spiritual coping in individuals with rheumatoid arthritis (RA) pain.
- 35 patients asked to keep a structured daily diary for 30 days of standardized measures of:
 - Spiritual experiences
 - Religious and spiritual pain coping
 - Salience of religion in coping
 - Religious/spiritual coping efficacy
 - Pain
 - Mood
 - Perceived social support.

Keefe et al. (2001)

- Participants reported frequent spiritual experiences such as feeling touched by the beauty of creation or feeling a desire to be closer or in union with God
- Also reported positive religious and spiritual coping strategies much more frequently than negative strategies.
- Variance largely due to differences between persons
- Also significant variability in daily scores.
- As much (or more) variability found in these measures over time as variability in pain.

Keefe et al. (2001)

- Individuals who reported frequent daily spiritual experiences had:
 - Higher levels of positive mood
 - Lower levels of daily negative mood
 - Higher levels of each of the social support domains.
- Individuals who reported that religion was very salient in their pain coping reported:
 - Much higher levels of emotional, arthritis-related, and general social support.

Keefe et al. (2001)

- Coping efficacy significantly related to pain, mood, and social support
- Higher ratings of ability to control decrease pain using spiritual/religious coping associated with less joint pain, better mood and increased social support.
- Findings suggest that daily religious/spiritual coping variables can be important in understanding coping with chronic pain.

Risdon et al. (2003)

- Understanding acceptance of chronic pain.
- Q-factor analysis of 30 participants
- **Eight factors** related to acceptance of chronic pain
 - Taking control
 - Living day to day
 - Acknowledging limitations
 - Empowerment
 - Accepting loss of self
 - More to life than pain
 - Don't fight battles that cannot be won
 - Spiritual strength.

Risdon et al. (2003)

- Common features:
- (1) Acknowledgement that a cure for pain is unlikely
- (2) Shift of focus away from pain to non-pain aspects of life
- (3) a resistance to any suggestion that pain is a sign of personal weakness.
- Accounts of chronic pain differed between participants in the extent to which acceptance of pain meant a change in core aspects of self.

Rippentrop et al. (2005)

- (*Pain, 116*)
 - Relationship between religion/spirituality and physical health and mental health in 122 MSK pain patients
 - Conceptualized religion/spirituality as multidimensional
 - Brief Multidimensional Measure of Religion/Spirituality
 - Pain patients' religious and spiritual beliefs appear different than the general population (e.g. pain patients feel less desire to reduce pain in the world and feel more abandoned by God).
 - Significant associations between components of religion/spirituality and physical and mental health.

Rippentrop et al. (2005)

- Private religious practice inversely related to physical health
- Perhaps as a way to cope with poor health.
- Mental health predicted by
 - Forgiveness
 - Negative religious coping
 - Daily spiritual experiences
 - Religious support
- Religion/spirituality was unrelated to pain intensity and life interference due to pain.

