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Religious Perspectives on Chronic Pain and Its Management

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It is hard to overemphasize the importance of religious perspectives for any national dialogue concerning chronic pain and its management. Numerous studies have documented the critical importance of religious perspectives in healthcare for chronic pain patients. Bush et al. conclude their study of religious coping with chronic pain by highlighting "the importance of examining religious coping to chronic pain management." Similarly, Harrison et al. "conclude that religious involvement likely plays a significant role in modulating the pain experience of African-American patients with SCD [Sickle Cell Disease] and may be an important factor for future study in other populations of chronically ill pain sufferers."[1]

Yet, in order to reflect coherently on the intersection between religious perspectives and chronic pain we must begin by disentangling three different issues:

1. In what ways may patients draw resources from their religious faith or spirituality as a form of coping and managing chronic pain?

2. In what ways may patients incorporate their religious faith or spirituality "to make sense" of their chronic pain? (This includes both "avoidable" and "unavoidable" pain.)

3. Why do some patients refuse opioids and other pain management resources for "avoidable' chronic pain, based upon religious reasons?

The first question, concerning ways in which patients may draw resources from their religious faith or spirituality to manage chronic pain, has been studied for at least 30 years.[2] Numerous studies have demonstrated that some religious/spiritual practices may prove efficacious in pain management strategies, even as other practices may not be efficacious.[3]

Our second question concerns ways that patients may incorporate their spiritual beliefs into the process of "making sense" of their chronic pain. Each of us carries our life story, which provides a vehicle for assimilating our experiences into an integrated narrative that gives life meaning and coherence. Metaphysical beliefs and commitments are key for the construction of this meaning-giving life story. Even the most radical atheist, who denies any reality beyond the physical, material world, must nonetheless construct a meaning-giving life story derived in part from their metaphysical perspective. Patients suffering from chronic pain must integrate this experience of pain into their life histories. For Christian patients, the existence of chronic pain almost inequitably provokes the question, "Why has God allowed this to happen to me?" This requires an explanation that makes sense and "fits" with their understanding of God as well as their life story.

We know that Christians vary tremendously in how they answer this question. For instance, Harold Koenig reports that a patient with chronic back pain interprets his pain as a means to glorify God, "And 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've got to carry this.' If there's a reason for it, if it's to glorify Him, then I'll carry it until the day I die."[4] Anita Unruh notes that "in the three monotheistic religions, Islam, Judaism, and Christianity…pain is punishment for the flawed nature of humankind and a means to improve one's nature."[5] Pope John Paul II argued that suffering could have redemptive value, writing that "it bestows courage, patience, resignation; it illuminates the mystery of our participation in the passion of Christ; it raises our inner gaze to true and complete happiness."[6]

A distinction must be drawn here between what Bosch and Baños describe as "avoidable" versus "unavoidable" chronic pain. "Avoidable" refers to chronic pain for which there are

efficacious opioids and other pain management strategies. By contrast, "unavoidable" refers to chronic pain for which there is no effective remedy.[7] This is a profound distinction, in which many observers – both Christians and non-Christians – could understand and empathize with patients for whom there is no effective pain management alternative, while finding the second option of refusing pain management simply baffling. It is important to note that although Pope John Paul II waxes eloquently on the benefits of suffering from chronic pain, he also values the work of physicians and other healthcare providers who seek out and utilize means of alleviating suffering. The Pope writes, "How much there is of 'the Good Samaritan' in the profession of the doctor, or the nurse, or others similar! …we can say that the parable of the Samaritan of the Gospel has become *one of the essential elements of moral culture and universally human civilization.*"[8] All religions and spiritualities can play an important meaning-giving role in cases where there are no effective opioids or other means of chronic pain control.

The alternative possibility is much more difficult for most of us to comprehend and appreciate. This brings us to the third question concerning where Christian patients who reject efficacious opioids and other pain management options because of their religious interpretation concerning their chronic pain. Kumasaka and Miles provide a good illustration of this possibility in their account of an oncology patient who refused morphine for her very intense pain. As the patient explained, "'If Jesus could suffer and die for me on the cross…then I can take my pain without any stronger drugs. This pain is God's will for my life.'"[9]

This perspective is not restricted to Christian patients, either. Eugene Thomas, in a study of Hindu renunciates, found that they accepted chronic pain as God's Will and as a means for spiritual growth. As one renunciate remarked: "Suffering is necessary. When you have suffering, you begin to feel deeper. Each moment of pain and suffering enables you to

understand when others suffer from it. This wideness of consciousness is a very important thing."[10]

Although there is plenty of anecdotal evidence, such as the illustrations provided by Kumasaka and Miles as well as Thomas, we do not really know how many patients refuse opioids and other pain management strategies. That is, we do not know if Kumasaka and Miles' patient represents an isolated minority – or the majority perception among religious and spiritual persons. Writing in 2007, Unruh concludes that "the literature contains no empirical research on the extent to which spiritual or religious views influence patients' use of pharmacological strategies or their preference with respect to nonpharmacological interventions such as cognitive-behavioural therapies."[11] My literature review confirms her assessment and suggests that no empirical studies have been published since 2007, either. This is a very puzzling question: Why do some religious patients accept opioids and other pain management techniques, while other religious patients refuse them? This question lies at the heart of the intersection between religious perspectives and chronic pain. This lack of any empirical data is really critical.

If I may limit my discussion to Christian patients for a few paragraphs, I would like to conclude by offering a hypothesis that Christians' acceptance or refusal of opioids and other forms of pain management hinges on how different individual Christians reconcile the theodicy question posed by chronic pain. The challenge of theodicy is an important, underlying theme – a red thread – that weaves through all three questions at the intersection of religion with chronic pain. Daniel Goldberg has astutely defined theodicy as the question: "How can an omnipotent, benevolent deity cause the innocent to suffer?"[12]

Genesis 1 provides a microcosm for the dilemma of Christian theodicy. Throughout this chapter God powerfully – almost effortlessly – creates the universe, our planet, and all of life on

the earth. At the end of this creation, God creates humans. But, unlike all the rest of creation, humans are special because they are created in God's image. That is, humans have a special relationship with God; they are beloved by God. This sets up the formula for the theodicy problem: How can an all-powerful God allow beloved human persons to suffer from chronic pain? If God is all powerful and all loving of human persons, then why does God allow humans to suffer from chronic pain? Christians have always wanted to believe that God is both all powerful and all loving; that is, both/and. However, the existence of "chronic pain" seems to require an '"either/or" position. That is, either God is all powerful and is not moved by the suffering of humans, or God truly loves and has compassion for persons but God is powerless to prevent chronic pain.

Historically, there have been a couple of frameworks for addressing this theodicy problem. First, a small minority of theologians – most recently process theologians – have opted to redefine God's power so that God is no longer omnipotent and therefore not responsible for everything that happens in the world. A second framework has taken the opposite approach and redefined God's benevolence. For these Christians, chronic pain may appear on the surface to be bad, but a deeper, more thoughtful analysis reveals that it is actually a good gift from a benevolent, omnipotent God. As an illustration, Koenig's patient is willing to endure chronic pain, if it glorifies God. Other responses have interpreted chronic pain as punishment for past sins, or by claiming that God has good reasons for allowing individual persons to suffer, but God's reasoning is beyond our lesser, human comprehension.

While trying to account for chronic pain by reconceptualizing God's omnipotence or love for human persons are two frameworks for the theodicy problem, some theologians would suggest an entirely different, third framework. Pastoral theologian Peggy Way, who has

struggled with polio in her own life, asserts that the theodicy problem appears to put Christians into the uncomfortable position of having to **defend** God.[13] Rather than trying to defend God, she proposes that humans embrace their finitude and truncatedness and live joyfully in the moment. She writes:

> When the religious sensibility focuses on a powerful God who will make all things right—or, on the other hand, on a good God who offers an entitlement of escape from terror, violence, and suffering if honored—the creature's capacities to live with joy within the given are truncated. And since the complexity of a world such as this exceeds the creature's conceptual capacity, churches themselves often become complicit in urging their followers to always transcend history rather than to practice living with joy and justice within it.[14]

Theological ethicist Stanley Hauerwas agrees with Peggy Way. Hauerwas observes that for "the early Christians, suffering and evil … did not have to be 'explained.' Rather, what was required was the means to go on even if the evil could not be 'explained.'"[15] Hauerwas argues that instead of a "problem with evil," the early Christians "had a community of care that…made it possible for them to absorb the destructive terror of evil that constantly threatens to destroy all human relations."[16] The historical watershed occurred when Christianity became the official religion of the Roman Empire under Constantine. Now, Christianity had a stake in the policies of the Christian Emperor. This eventually led to the Christian assumption that humans control their destinies. However, the presence of evil threatens this worldview and so theodicy, the problem of evil, emerges for Christians in the modern period. Hauerwas writes:

> The ideology that is institutionalized in medicine requires that we interpret all illness as pointless. By "pointless" I mean that it can play no role in helping us live our lives well. Illness is an absurdity in a history… . I suspect that this is one of the reasons we have so much difficulty dealing with chronic illness—it should not exist but it does. It would almost be better to eliminate the subjects of such illness rather than to have them remind us that our project to eliminate illness has made little progress.[17]

Similar to the conclusion by Peggy Way, Hauerwas asserts that the way to address the theodicy problem is not by trying to defend God in terms of omnipotence or love. Rather, he suggests, "if Christian convictions have any guidance to give…it is by helping us discover that our lives are located in God's narrative—the God who has not abandoned us even when we or someone we care deeply about is ill."[18]

My hypothesis is that Christian patients who refused opioids and other pain management options are working out of the first framework that requires the faithful to defend God from God's seeming impotence in preventing pain and suffering. Christians working within this framework may feel compelled to find some good that occurs because of the chronic pain and thus they reject opioids. By contrast, Christians working from out of the third framework proposed by theologians, such as Way and Hauerwas, may not feel compelled to defend God. Instead, they would not assign greater meaning to their chronic pain. Since they do not feel compelled to defend God and find some greater good from the pain, they may be more receptive to opioids and other pain management options.

Of course, all of the above is just a hypothesis because we do not have any empirical data that tell us how many religious persons refuse opioids and why. The lack of such empirical data is tragic, and I believe that a joint qualitative/quantitative study should be integral to the launch of any new national initiative on chronic pain. The qualitative component of the study would enable the skilled interviewer to get at the question of why some religious believers forego pain management options. The quantitative component would help determine the number of religious/spiritual patients who take this perspective. If I were pursuing such a study, I would begin by conducting qualitative one-on-one interviews with 20-25 patients who have chosen to forego pain treatment and an additional 20-25 patients with strong religious beliefs and

spiritualities who have chosen to use opioids. Then, I would use an analytical methodology, such as "Grounded Theory" from Sociology, to identify recurring themes and rationales for foregoing pain management. These themes and rationales could then be developed into a quantitative survey for more broader sampling.

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[1] E. Bush et al., "Religious Coping with Chronic Pain," *Applied Psychophysiology and Biofeedback* (1989) and M. Ojinga Harrison et al., "Religiosity/Spirituality and Pain in Patients with Sickle Cell Disease," *Journal of Nervous and Mental Disease* 193, no. 4.
[2] As early as 1981, Yates et al., published "Religion in Patients with Advanced Cancer" in *Medical and Pediatric Oncology* 9 (1981): 121-128.
[3] See, for example, E. Bush et al., "Religious Coping with Chronic Pain," *Applied Psychophysiology and Biofeedback* (1989). M. Ojinga Harrison et al., "Religiosity/Spirituality and Pain in Patients with Sickle Cell Disease," *Journal of Nervous and Mental Disease* 193, no. 4. A. Bässing et al., "Are Spirituality and Religiosity Resources for Pateints with Chronic Pain Conditions?" *Pain Medicine*10, no. 2 (2009). J. Dezutter et al., "Exploring the Link Between Religious Attitudes and Subjective Well-Being in Chronic Pain Patients," *International Journal of Psychiatry in Medicine* 39, no. 4 (2009). Anita Unruh, "Spirituality, Religion, and Pain," *The Canadian Journal of Nursing Research* 39, no. 2 (2007). Harold Koenig, "An 83 year old Woman with Chronic Pain and Strong Religious Beliefs," *Journal of the American Medical Association* 288 (2002): 487-493. Harold Koenig, *Chronic Pain: Biomedical and Spiritual Approaches* (New York: Haworth Pastoral Press, 2003).
[4] Koenig, *Chronic Pain,* 46.
[5] Unruh, 73. She cites Harold Koenig et al., *Handbook of Religion and Health* (Oxford: Oxford University Press, 2001).
[6] Pope John Paul II, *The Loving Heart: Private Prayers of John Paul II*, vol. IV, anonymous translation (New York: Atra Books, 2004), quoted by J. Garcia, "Sin and Suffering in a Catholic Understanding of Medical Ethics," *Christian Bioethics* 12, no. 2 (2006).
[7] Fèlix Bosch and Josep E. Baños, "Religious Beliefs of Patients and Caregivers as a barrier to the Pharmacologic control of cancer pain," *Clinical Pharmacology Therapeutics* 72, no. 2 (2002): 109.
[8] Pope John Paul II, "On the Christian Meaning of Human Suffering" 11 February 1984.
[9] Lydia Kumasaka and Al Miles, "My Pain Is God's Will," *American Journal of Nursing* 96, no. 6 (June 1996): 45-47.
[10] L. Eugene Thomas, "Identity, Ideology, and Medicine: Health Attitudes and Behavior Among Hindu Religious Renunciates," *Social Science and Medicine* 34 (1992): 501.
[11] Unruh, 76.
[12] Daniel S. Goldberg, "Job and the Stigmatization of Chronic Pain," *Perspectives in Biology and Medicine* 53, no. 3 (2010): 428.
[13] Peggy Way, *Created by God, Pastoral Care for All God's People* (St. Louis: Chalice Press, 2005.
[14] Way, 148.
[15] Stanley Hauerwas, *god, Medicine, and Suffering* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1990), 49.
[16] Hauerwas, 53.
[17] Hauerwas, 63.
[18] Hauerwas, 67.