

## **Pain and Spirituality**

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### **Introduction**

Teaching in the field of pain medicine seems to be dominated by emphasis on pain as a symptom. This is a natural response to the scientism that dominates our medical training, thinking and practice. The topic of pain and spirituality affords us the opportunity to re-focus our attention on the multidimensional aspects of the pain experience, as many have so eloquently done before. (1,2,3) We introduce our topic by posing several questions:

How important is spirituality in the lives of patients?

How important is the spirituality in the lives of physicians?

What role does spirituality play in health/wellness, recovery from illness, and relief from suffering?

How can physicians attend to patients spiritual needs?

Can we understand some concepts of spiritual experience in neurophysiological terms?

Can such understanding help bridge the gap between the scientific and the spiritual?

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“Pain” and “Spirituality” are terms that everyone understands, but everyone understands them uniquely. The same words may convey different means to different people. “Pain” and “spirituality” are laden with meaning and with ambiguity. In many ways they are beyond the ability of words to describe. Yet it is language we must use to communicate life’s innermost and most personal experiences, and their close, ineffable relationship. In order to create a shared understanding that will be important to physicians, no less than patients, we will explore the layers of nuance in pain and spirituality. Especially the conversations physicians must be prepared to have with their patients depend on some level of mutual understanding and empathy. What is pain? What is spirituality? How do we communicate our experiences of these to others? How do we understand what others intend when they try to communicate their experience to us?

Pain is a universal human experience, which in the modern (or postmodern) era may be understood to be either physical or mental/emotional. In fact it may be both. The dictionary definition reflects this cultural dualism. It tells us that pain is either physical suffering or discomfort (in a particular part of the body) caused by illness or injury or that pain is mental suffering or distress (New Oxford American Dictionary). Body or mind. Either/or. It wasn’t always this way. Aristotle thought of pain as an emotion, like joy. Descartes, who ushered in the idea of a mind-body split, considered pain a sensation. Are physical pain and emotional pain different experiences or different aspects of the same experience? There is an obvious difference between a toothache and heartache, but does it make sense to think of unpleasant experience as issuing from separate realms? We might be tempted to say from a medical point of view that

pain is a symptom, a problem, something to be treated or eliminated. And often it is. But we would not wish for a world without sensation. We would not wish to eliminate the warning pains that teach a child to pull its hand away from a fire. We would not wish for a world without emotions, the joys that put our sorrows in perspective or vice versa. These are the experiences that make us human, that give life meaning. It is not always fun. It cannot be.

The question of meaning leads us to the relationship of pain and spirituality. Spirituality, like pain, is richly laden with meaning and ambiguity. For many people, spirituality can be equated with religion. For many people, their faith, their religion, provides a source of meaning and comfort and understanding. It makes life bearable. It may alleviate pain and suffering. In this sense religion (or spirituality) becomes medically interesting. But for others, religion may be problematic, a source of dogma, discomfort, or divisiveness. So we are led to make distinctions. We look for the clear and distinct idea that so inspired Descartes, but we communicate with languages rich in nuance and ambiguity, that evoke meanings, rather than truncate them. Spirituality may be of benefit and satisfaction even for those who do not identify with a particular religion or sect.

### **Religious or Spiritual?**

In the latter part of the twentieth century, there has been a trend to distinguish between religion and spirituality. Older (pre-1960's) definitions of "religion" and "spirituality" typically saw the two as interpenetrating, often interchangeable concepts. Most frequently spirituality was viewed as the intensely internalized aspects of one's espoused religion. Religion has its times of general spiritual intensification. Spirituality was often considered a path or discipline for incorporating religious precepts into one's personal living and consciousness. Spirituality's

connection to religion with its theological and ritual dimensions overseen by a priesthood of some kind was considered essential to keep spirituality “within rational bounds” and not spinning out of control. Beginning with the 1970’s, articles related to religion and spirituality began to appear with increasing frequency in the psychotherapy literature. Those articles that defined religion and spirituality in mutually exclusive terms tended to value spirituality and be dismissive of religion. Definitions that saw them as overlapping tended to value both. (4,5,6)

In the current phase of intensified interest in spirituality and religion, the option of regarding oneself as “spiritual” but not necessarily “religious” has increased dramatically. “Religion” in many instances is more closely aligned with the political than with the spiritual, while spirituality retains the sense of a personal concern with meaning and transcendence. These concerns may or may not be grounded in institutional beliefs and practices. Whether this concern for the transcendent necessarily involves the sacred is a matter of personal consideration. Being captivated by a sunset, a sports team, or a political campaign is not intrinsically a spiritual experience simply because one feels connected to something larger than oneself. However, if these experiences are imbued with a sense of connection with the sacred, or ultimate reality, or things as they really are, then that would represent a spiritually significant experience. The ordinary activities of everyday life can thus become invested with spiritual meaning as is the case for a Buddhist focusing mindfully on sweeping the steps or eating a raisin, a Jew reciting a prayer while washing his hands, or a Catholic who views preparing a meal as a sacrament. In this sense both religiousness and spirituality are seen as reflecting “the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred.” (4)

What might spirituality be, then, if not an approximate synonym for religious?  
Spirituality derives from spirits, ghosts and the rituals that primitive cultures have developed to

help cope with the feelings of lost loved ones. We now say more respectfully “traditional cultures”, but our euphemism belies the connection with an unrefined, unenlightened, unscientific, struggle to make sense and find meaning of a world beyond our control.

## **Pain and Evil**

Evil stands as the antithesis of good, that which is valued. Evil is bad, and pain is disvalued, hence bad, hence evil. Evil is sometimes divided into natural evil, events beyond human control such as tsunamis and earthquakes, and man-made (human-made) evil, the bad things that people do, assaults, murders, and perhaps wars, the activities of sociopaths who act outside the bounds of conscience and civil responsibility. Illness (and pain) defy such classification. While disvalued, they are not necessarily caused unless one believes in an omnipotent being who causes everything. Such a belief challenges faith. Why would an omnipotent being cause suffering? If not as a deserved punishment, it would clearly be an injustice. This apparent contradiction is called theodicy, the vindication of divine goodness and providence in view of the existence of evil. Why would bad things happen to good people? The question is important not only for those who consider themselves religious, but for anyone who experiences suffering and tries to make sense of their experience. It is a conversation doctors should be having with patients, whose insights about their pain experiences offer clues for ways to help relieve their suffering.

## **The case of Job**

The Hebrew Bible (Old Testament) poses this question in the Book of Job in the context of man’s relationship to God.

Job a very pious and prosperous man. He had seven sons and three daughters and many possessions. He constantly feared that his sons may have sinned and cursed God in their hearts, so he offered burnt offerings as a pardon for their sins. God asks Satan his opinion of Job, and Satan suggests that he is only pious because he is prosperous. God gives Satan permission to destroy Job's family and his possessions. In spite of these losses, Job remains faithful. "YHVH has given and YHVH has taken away" (Genesis 31:9). Job does not curse God, but he does question him. Satan asks for permission to afflict Job's body as well and causes Job to break out in boils. Still he does not curse God, even when his wife urges him to do so. Job's three friends, Eliphaz, Bildad, and Zophar, believe that Job must have sinned to incite God's punishment. They believe Job must deserve his suffering because God always rewards good and punishes evil. Job's fourth friend Elihu takes a different view. He argues that Job may not have committed a specific sin for which he is being punished, but that the he is not perfect, and God as creator is such that his motives cannot be questioned by man. Elihu stresses that real repentance entails renouncing moral authority (the knowledge of good and evil), which is God's alone. Elihu therefore underscores the inherent arrogance in Job's desire to 'make his case' before God, which presupposes that Job possesses a superior moral standard that can be prevailed upon God. Job prays for forgiveness (for himself and his friends) realizing that he cannot understand the ways of God. His wealth is restored twofold; he is given seven more sons and three more daughters and lives to see the fourth generation.

This kind of introspection lies at the heart of one of the most successful disciplines in the treatment of addiction disorders, the Twelve Step Programs of Alcoholics Anonymous and related community organizations such as Narcotics Anonymous. Although not widely used it may have direct applicability to those suffering with chronic pain and other chronic illnesses (7)

### **Pain and Suffering**

David Morris, in his far reaching analysis of pain in our culture, *The Culture of Pain*, has probably gone farther than anyone else in highlighting the tension and contradictions in our

modern understanding of pain. (8) He observes “The secular, scientific spirit of modern medicine has so eclipsed other systems of thought as almost to erase the memory that pain—far from registering its presence mostly in meaningless mental circuits or in some sterile, living-death of hysterical numbness---once possessed redemptive and visionary powers. We need to recover this understanding partly because it shows so clearly how pain inhabits a social realm that sprawls well outside the domain of medicine.” Suffering is a passive experience.

Something bad or unpleasant, like pain or illness, befalls the person. What Morris is suggesting is that the interpretation of that experience may be redemptive in some way, as with the twelve step programs. Understanding this may put suffering into a different context that allows an individual to overcome it, at least conceptually, by active mastery. That taking control may be religious or spiritual or even political in some self-chosen way, a way that modern medicine may have forgotten or dismissed.

### **The Case of Ivan Ilych**

Ivan Ilych was an ordinary man, Tolstoy tells us in his famous story, *The Death of Ivan Ilych*. He had noble qualities. He was cheerful, good-natured, and industrious. After he graduated from law school, his successes led him from one position to another, marriage, children, a nice house, and a life many might find enviable.

It was while decorating his house that he fell from a ladder, a downfall as it were, hurting his side. Pain entered his life, but it subsided. But it was followed by other sensations, a bad taste in his mouth, a pressure in his side where the pain had been. He became worried and preoccupied. He became irritable and withdrew from social activities. He stopped playing cards with his friends. He saw doctors, got prescriptions, more doctors, and more prescriptions. His pain in his side became a constant ache, which consumed his attention.

His appearance changed, and this bothered him. It occurred to him that he might be dying, but his family continued to deny this possibility. He doubted his life, the reality of his

accomplishments. When he realized that his life had been unalterably changed, he began to scream and he screamed for days. When death finally came, it was anticlimactic. Ivan Ilych, as he was once known, had already been dead for a long time.

Ivan Ilych's pain takes over his life so gradually that it is almost imperceptible. It is only by contrasting what he was with what he became that we appreciate how dramatic the change was. Tolstoy doesn't tell us exactly what was wrong with poor Ilych. He suggests that it was related temporally to the fall from the ladder, but that it might have been something different. Was it in his mind or his body or should he try to make that distinction? Tolstoy's story presents us with a distinction between the death of a person as a whole and the death of the whole person long before we began to worry about brain death.<sup>3</sup>

### **The role of spirituality in the lives of our patients**

Larry Dossey, MD, has reviewed the world literature (more than 2,000 studies) on the role of spirituality and compassion on health stating that roughly half have shown positive statistical significance(9) and that spirituality/religious involvement correlates with decreased health problems and morbidity. He suggests that healing may be more likely to occur only in the hands of dedicated "healing experts." He discusses the famous Harvard study about intercessory prayer (10), noting while the effects of prayer in this study were statistically positive the study could not be duplicated elsewhere. Dr. Dossey suggests that the difference was the "expertise"

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<sup>3</sup> The distinction between "the death of the whole of the person" and "the death of the person as a whole" was introduced by Otto Guttentag ("The Meaning of Death in Medical Theory," Stanford Medical Bulletin, 17 (August 1959), pp. 165- 170.) to help appreciate the need for brain death criteria in deciding when to turn off artificial respirators. The Death of Ivan Ilych may be seen as the reciprocal situation. Psycho-somatic and somato-psychic being in truth much the same thing. In trying to understand human experience we focus on the effect not the cause.



and good intentions of those offering the prayer in the Harvard study versus a more scientific experimental design, utilizing people with less experience

For a period of two years, thanks to the generosity of the owners of a private rehabilitation center where I carried out my work (RLS), we had as a regular member of the staff an ordained minister who offered both formal and informal spiritual guidance to our patients. Although a Christian minister, she was very much attuned to the spiritual needs of non-Christians and non-practicing Christians. In addition to receiving voluntary counseling the patients were given homework and reading assignments to help them get more in touch with their spiritual sides. Those with addiction disorders were also encouraged to actively participate in twelve step community programs. As one of my duties at this center I conducted exit interviews on hundreds of patients who had completed this multidisciplinary pain treatment. One of my questions was a general one, “What things meant the most to you in your time here at the clinic and what was the least helpful?” Almost invariably, somewhat to my surprise, was the answer that the “minister” had by far been the most helpful. When asked why, responses like “learning to cope” and “experiencing less suffering” were common answers.

Peter Levine, author of “Waking the Tiger, Healing Trauma”, notes the emergence in many patients of spiritual epiphanies as they successfully master significant physical and emotional trauma and suggests a common physiology if healing trauma is done gradually so that suppressed “survival energy” doesn’t emerge rapidly and overwhelm the individual. Gradual therapeutic movement in this direction provides a vital resource for helping people reengage into life after the devastation of trauma. This is a feeling experience, similar to that experienced in virtually every religious tradition, where suffering is understood as a doorway to awakening. (11,12)

## **The role of spirituality in the working lives of physicians**

Recent surveys and papers reflect a growing interest among physicians about spiritual issues, including mindfulness, belonging to an organized religion and formal spiritual techniques such as prayer and meditation (13,14,15). In order to address those issues, many health care professionals have relegated the job to spiritual counselors such as hospital chaplains. We suggest, however, that the spiritual dimension of patient's lives is too important for the physician to ignore. For many Pain Medicine practitioners that might call for a significant paradigm shift and we would suggest a new medical model of treatment to accomplish that. George Engel identified the need for "a new medical model" in 1977. (16) The model he proposed was a bio-psycho-social model intended to expand the bio-reductionistic model then in force. The bio-reductionistic model held that everything you need to know about medicine could be explained by reducing illness to its biological components. That model was extremely successful up to a point. There had been many advances in biomedicine that supported the treat-the-body-as a machine approach. Even organs could be replaced intact like the worn out parts of an old automobile. Now three decades after the publication of Engel's article, we appreciate that the biological model did not explain enough. We realize how mind (and stress) affect the body-machine and how so many of the illnesses people suffer stem from behavioral causes with physiological correlates.

In defense of Engel's originality and insight, it could be said that spirituality is implicit in his consideration of the psycho-social. But it must also be recognized that the discussion of spirituality in modern Western thought is strained and uncomfortable. It

could also be said that a failure to distinguish the spiritual from the religious has impeded a broader consideration of the spiritual.

In opening up the possibility of a conversation about the role of spirituality in health care, we are aware that we would need to consider everything from the array of organized religions to the most unique forms of New Age individualism. And that is precisely the point. Each patient, each person comes to medicine with his or her own unique experience and outlook and needs. And they may find their own unique path to healing. The doctor and healthcare team do not need to share the same experience, but they need to understand the uniqueness of each person's psycho-social and spiritual needs, as well as their own. The team needs to be aware of the impact their own spiritual belief systems have on their interactions with their patients.

Rachel Naomi Remen, MD has developed a curriculum, *The Healer's Art*, that is now used in over thirty medical schools in the United States, which pays explicit attention to spiritual issues in healing, broadly understood. (17) She also offers ongoing retreats for doctors on this same subject who either wish to teach the subject or who have become in some way dispirited themselves and are in need of refreshing. (18) As part of these seminars physicians are introduced to the simple practice of starting each day with yoga and meditation and *remembering to dedicate oneself each day in practice to our patients*. In the course of doing this, one becomes more mindful of patients' needs and a better listener. This is an informal spiritual practice that, sadly, many healthcare practitioners have abandoned or never even thought about. Indeed, in a series of focus groups held 10 years ago by the National Pain Foundation patient's suffering with chronic pain repeatedly stated that among their greatest needs were healthcare professionals who would listen to them and validate their pain and suffering; something they felt had been sorely

missing in their lives. Attention to the office as a quiet and calming space may help patients as well as physician relax and focus on the emotional as well as physical aspects of their concerns.

### **A neurophysiologic basis for spiritual experience**

Andrew Newberg, M.D., a radiologist and psychiatrist at the University of Pennsylvania, discusses the difficulty in matching subjective experiences (which are so variable among individuals and cultures) and objective measures. Neurophysiological changes such as can be measured with functional ( f MRI) only capture some of the picture but show that a vast network of brain structures are involved in such practices as prayer and meditation. For example, parietal lobe structures deactivate as practitioners experience a sense of losing themselves while at the same time limbic areas such as the amygdala and hippocampus become active with intense spiritual/emotional experiences. So, too, are there measurable levels in hormones during such experiences. (20)

James Austin, MD, Clinical Professor of Neurology at the University of Missouri-Columbia is an academic neurologist. Dr. Austin has studied in Delhi, India and Kyoto Japan. His highly technical and intellectual discussion in the book Measuring the Immeasurable (21) offers a more in-depth discussion of the complexities of the science behind our subject. However, all of our growing understanding of the neurophysiology associated with spiritual experience still begs the question of why humans were given this gift of transformative mind.

### **Putting spirituality into everyday practice**

Death, loss suffering, and pain, are all part of the human condition. Though we may lament, rail and complain, we cannot escape their inevitability. Our challenge is what to do and how to understand in the face of a fate that may seem almost unbearable and unacceptable. Physicians and healers attending to those who suffer must be mindful of what their patients experience. Sometimes when it is not possible to remove patients' afflictions, the task of the healer to help the patient bear what cannot be removed. For each of us, part of the task is coming to comprehend how to live a life that might be less than what we would hope for.

That struggle inevitably takes time and has been described as "stages of grief". See Table 1. Though the words people may use to describe feelings may vary, there are some commonalities. (22,23) The notion that when faced with a loss or diagnosed with a serious illness, people go through a series of "stages" has become widespread in lay and professional circles. (24) There are no invariant rules, and several nomenclatures illustrate the process. Immediately people tend to experience some sense of shock, denial, or at least disbelief that such a thing could happen. Almost all descriptors convey some sense of anger, which may be one of the most problematic emotions and difficult to deal with, especially if it is displaced, as it often may be, on the person trying to be helpful and responsive. It may be one of the most difficult things for physicians to deal with. Some sort of sadness, depression, self-pity may follow, especially if open communication of feelings is not encouraged or tolerated. Eventually one may come to some sort of acceptance, which does not necessarily mean that everything is alright, but rather that the inevitable reality is acknowledged. For physicians and health professionals, the task faced is how to attend to such suffering. How should one enter into conversation with patients? Are there questions to be asked? Comments to be made? A general rule would be to start with open-ended questions, and LISTEN. Let the person narrate his or her own experience.

Avoid judging or being prescriptive. These are challenging and sensitive areas because the basis for empathy is our experience even as we realize that others may experience and understand things differently, especially in spiritual matters.

Table 1 offers a developmental approach, which places Fowler's Stages of Faith alongside stages of psychological (and physical) development. Table 2, the FICA Spiritual History tool, could be adopted for office use and suggests some widely used approaches to thinking of human development.(25) The stages offer the practitioner self-discipline to minimize assumptions about how someone should behave or respond. Developmental and stage theories help expand the assessment of the patient as an empathic aid to understanding what their world might be like. For example, to say that someone is being "childish" can be harsh and judgmental. To realize that in the face of a threatening illness even an adult may struggle, and to approach their suffering in a sympathetic and helpful manner, may be the best that one can offer.

### **Ethics, Pain and Spirituality**

Religion and spirituality are for many a main source for ethical values, reasoned and understood. For the health professional, shared ethical norms orient healing activities in a way that patients, clients, or consumers, can depend on the person from whom they seek help. The principle of beneficence, respect for autonomy and self determination, informed consent, confidentiality, competence are all norms which have governed professional behavior at least since the time of Hippocrates.

One ethical principle demands special attention in the area of religion and spirituality: the respect for boundaries. This is most basically seen in the proscription against sexual activity

with patients. Also it is the basis for the prohibition against entering into a business relationship or other dual relationship. It stems from the recognition that the patient is a different person, not an extension of the professional and not available for the gratification or exploitation of the professional. This can be problematic in the area of dependency relationships, where in fact the patient does need the expertise of the professional. It is ethically incumbent on the professional to recognize that need and not exploit it.

Another boundary that is important for the professional to recognize is the spiritual boundary. If the professional has strong religious beliefs, he or she must be careful not to attempt to impose them—even subtly—on the patient, realizing that we are not in a position to understand the mysteries of the ultimate.

### **Conclusion**

We hope the preceding discussion will encourage a significant paradigm shift in the world of Pain Medicine today. Pain is much more than a medical problem, and medical attempts to eliminate or alleviate pain must also account for the complexities of human suffering. Medicine alone does not solve the problem of pain. Our scientific quest to conquer pain only underscores the reality of its complexity and heightens its mystery. The founders of the American Academy of Pain Medicine understood and emphasized the multidimensional nature of pain and the strong need for multidisciplinary approaches to its evaluation and treatment. There have been many scientific advances in the subsequent decades since, most of which have shifted the focus of attention once again to pain as a symptom, subject to potential eradication by the wonders of our technology and pharmacologic prowess. These advances need to be coupled with a reawakening about the other important dimensions of pain, including the spiritual. There are many roadblocks

to doing so. (26) The training of the post-modern twenty-first century Pain Medicine physician should reemphasize the importance of psychosocial and spiritual treatment if we are to achieve our goal as a truly unique medical specialty.

Page 16 Table 1

Page 17 Table 2

Pages 18-19 References



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<b>E. Kubler-Ross<sup>4</sup></b>	<b>H. Lowenbach<sup>5</sup></b>	<b>W. Dyer<sup>6</sup></b>
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<sup>4</sup> Elisabeth Kubler-Ross' nomenclature has become almost standard for "The Stages" and is the basis for many conversations about loss and death, especially pernicious diagnoses like cancer.

<sup>5</sup> Hans Lowenbach was Professor of Psychiatry at Duke University through most of the latter half of the twentieth century. He was a much-admired mentor to generations of physicians for his practical clinical wisdom and sharp insights.

<sup>6</sup> Will Dyer wrote a college term paper for a German course based on "Der Ackerman und Der Tod", choosing German words (here translated) to describe the experiences of the farmer. Their applicability to other situations expands the nuance<sup>6</sup> Elisabeth Kubler-Ross' nomenclature has become almost standard for "The Stages" and is the basis for many conversations about loss and death, especially pernicious diagnoses like cancer.

### **Table 2 – The FICA Spiritual History Tool**

How would you like me, your healthcare provider, to address these issues in your healthcare?"

Source: The George Washington University Institute for Spirituality and Health. Accessed at [www.gwish.org](http://www.gwish.org) on May 4, 2009.

The FICA Spiritual History Tool

#### **F – Faith and Belief**

"Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds "No," the health care provider might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

#### **I – Importance**

"What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"

#### **C – Community**

"Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

#### **A – Address in Care**

**Table 1**  
**Stages of Faith and Child Development[17, 21, 22]**

Age Group	Fowler's Stages of Faith	Developmental Stages (Erikson and Piaget)	Key Attributes
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Infancy	Undifferentiated Faith	Trust vs. Mistrust (Erikson)  Sensorimotor (Piaget)	<ul style="list-style-type: none"> <li>▪ Development of basic trust through relationship with parents or primary caregivers; attachment sets the stage for future relationships</li> <li>▪ Consistency and dependability of caregiving responses and rituals counter feelings of anxiety and mistrust</li> <li>▪ Experiences mediated through senses and physical exploration</li> </ul>
Early Childhood	Intuitive-Projective Faith	Autonomy vs. Shame <i>Followed by Initiative vs. Guilt</i> (Erikson)  Preoperational (Piaget)	<ul style="list-style-type: none"> <li>▪ Literal and concrete thinking</li> <li>▪ Imitative, reflects religious beliefs and behaviors of parents/caregivers</li> <li>▪ Beginning to develop a sense of right and wrong, drawn to clear-cut representations of good and evil</li> <li>▪ May judge things, experiences, or self according to outcome—e.g., viewing illness as a punishment; poor understanding of cause and effect</li> <li>▪ Concerned about security, safety, and the power of caregivers to protect</li> </ul>
School Years	Mythic-Literal Faith	Industry vs. Inferiority (Erikson)  Concrete operations (Piaget)	<ul style="list-style-type: none"> <li>▪ Fairness is an important construct in understanding the world</li> <li>▪ Beginning to take on the stories, beliefs, and observances that symbolize belonging to one's community</li> <li>▪ Superstition and magical thinking may be evident, but symbols and concepts remain concrete and literal</li> <li>▪ Fuller understanding of cause and effect</li> <li>▪ Increasing ability to separate own perspective from that of others</li> <li>▪ Beginning to recognize that rewards and punishments do not necessarily correlate to actions (“bad things happen to good people”)</li> </ul>
Adolescence into Young Adulthood	Synthetic-Conventional Faith  <i>Followed by Individuative-Reflective Faith</i>	Identity vs. Role Confusion (Erikson)  Formal Operations (Piaget)	<ul style="list-style-type: none"> <li>▪ Development of abstract thinking, flexibility of perspective taking</li> <li>▪ Sense of identity and “interiority” are utmost concerns</li> <li>▪ Ability to integrate diverse and even contradictory elements into self-identity</li> <li>▪ Attachment to beliefs and personal expression of significant people in their lives</li> <li>▪ Dependence on others for validation of and clarity about one's identity</li> <li>▪ Experience of the world extends beyond the family to school, work, peers, “street society,” the media</li> <li>▪ Search for identity may include questioning beliefs and practices of family</li> <li>▪ Toward end of this stage, critical reflection leads to intentional choices and renewed clarity about personal ideology and belief systems</li> </ul>

Denial	Denial	<i>Unglaube</i> (Disbelief)
Anger	Anger	<i>Zorn</i> (Anger)
Bargaining	Accusatory	<i>Selbstmitleid</i> (Self-pity)
Depression	Self-accusatory	<i>Traurigkeit</i> (Sadness)
		<i>Gott flehend</i> (Pleading with God)
Acceptance	Acceptance	<i>Anerkennung</i> (Acknowledgment)

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