

CANCER PAIN AND THE IMPORTANCE OF FAITH IN ADDRESSING SUFFERING BEYOND THE PHYSICAL

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Abstract: Inadequate response to analgesia in a patient with severe physical pain due to advanced cancer prompted exploration of psychological and spiritual contributory factors. Robust discussion with the palliative care consultant, psychiatric nurse, and chaplain resulted in psychological and spiritual wholeness and peace, and improved pain control for the remainder of her life.

Key words: Total pain; spirituality; multidisciplinary working; spiritual care

Case history

A 52 year old artist presented to her General Practitioner with symptoms of acid reflux, which did not respond to first line measures and she was referred for urgent investigation. The GP's letter stated that the patient was convinced she had oesophageal cancer and was very anxious. Hospital investigations, including endoscopy, confirmed the presence of extensive poorly differentiated stomach cancer.

Shortly after completing chemotherapy she was readmitted with diffuse abdominal pain accompanied by anorexia, nausea and weight loss. A repeat endoscopy at this stage demonstrated extensive residual tumour in the stomach. The symptomatology was exacerbated by marked anxiety, and a palliative care assessment was requested.

The patient had severe generalised abdominal pain, frequent nausea intensified by attempts to eat, and occasional hiccups. Examination revealed a tender abdominal mass. Discussion ranged around the nature and significance of her disease, and the loss of a daughter from cancer five years beforehand.

Initially the pain appeared to be satisfactorily explained by direct tumour infiltration, and treatment was commenced with steroids, and opioid dose titration according to accepted palliative care protocols. However, an early improvement in pain was not maintained despite subsequent increases in analge-

sia, and this prompted deeper exploration of non-physical contributors. The patient acknowledged

suppressed grief following the loss of her daughter, and personal and family conflict provoked by her resort to heavy alcohol consumption at that time, heightened by her austere interpretation of Christianity based on her understanding of her childhood denominational exposure.

An inconsistent behavioural pattern of seeking, and then angrily rejecting attempts to ease pain had generated antipathy amongst the ward staff and she was now labelled a 'difficult' patient. The palliative care consultant, a Christian, concluded that the patient was desperate to have forgiveness and a restoration of peace, but her disillusionment with Christianity, as she understood it, made it very difficult to help her. The spiritual and psychological issues prompted referrals to the psychiatric liaison nurse and to the hospital chaplain.

Referrals

The psychiatric liaison nurse found difficulty establishing a therapeutic relationship with the patient, who demonstrated marked incongruity of affect when relating past and present events. She rejected helpful interventions from medical and nursing staff, and therapeutic suggestions from the psychiatric nurse himself, including relaxation therapy and the use of art as an expressive medium, perhaps because she was unable to recognise emotional responses in herself and others.

On the second consultation the patient was found lying in a darkened room, clearly in pain, and expressing hostility to nursing staff for allegedly failing to dispense adequate and timely analgesia. In

reality she had refused medication when offered, preferring to achieve pain control without use of drugs. However she readily accepted an anxiolytic with obvious benefit, and then engaged in discussion about her life, missed opportunities, and her sense of loss at her own impending death at a young age. She was unable to express openly her grief at the death of her daughter for fear of compromising the relationship with this daughter's living twin sister.

A further consultation at home demonstrated continued suppression of grief, and collusion with her husband in denying the realities of a short prognosis.

The patient addressed numerous issues with the help of the chaplain. She had a clear wish to explore and re-evaluate faith and beliefs in the light of her diagnosis and prognosis. She expressed a desire for:

- (i) a 'spiritual mentor'
- (ii) for someone who could challenge her preconceptions and
- (iii) handle the resultant spiritual dialogue.

She raised two particular questions with the chaplain: "Is Christianity true?", and, "Is this a truth that saves *me*?"

The patient acknowledged the influence of her denominational background, with emphasis on an angry and judgemental God. Whilst recognising the truths about God's anger towards and judgement of sin, the chaplain, who had a similar cultural background, emphasised that God is fundamentally loving, gracious and forgiving.

Issues of loss were addressed, particularly her grief at the death of her father, then her infant son, and finally her teenage daughter. The chaplain facilitated her expressions of anger and deep sadness and she became able to discuss these issues with her husband and surviving children.

Supportive and honest discussion also focussed on the patient's hostility towards members of staff, and occasionally towards the chaplain himself. The patient later acknowledged that this had been a defensive reaction to her own vulnerability.

During this time the patient had been advised by a member of her denomination that spiritual security could only be found in a re-affirmation of membership of that particular denomination. She had also been led to believe that expression of her artistic gifts was idolatrous and that she would have to abandon these if she were to have reconciliation with God. A similar ethic applied to non-Christian literature or music.

Consultation with the chaplain helped the patient to resolve denominational issues from core issues of Christian faith. Although occasional ruminations about an indiscriminately condemning God still caused fear and despair she gradually recognised a growing faith which she eventually found sustaining as death approached, laterally articulated as, "I believe that Christ has called me by name, and I am His."

This sustenance was particularly evident when her pain improved significantly whilst talking, praying, or reading scripture with the chaplain. A person manifestly in pain would become relaxed and even cheerful following a time of prayer or reading or conversation about spiritual issues. Moreover, a personal alignment with the emotions expressed in Psalm 130 '*Out of the depths I cry to you, O LORD*', caused a deeply cathartic outpouring of emotion, following which she was able to address issues of grief and loss.

Discussion

In a seminal address to Harvard medical students in the 1920s, Dr Francis Peabody emphasised the importance, to diagnosis and management, of recognising the *person* and not just the disease process (Peabody 1927). He said, "*Sickness produces an abnormally sensitive emotional state on almost everyone, and in many cases the emotional state repercussions on the organic disease.*"

Dame Cecily Saunders, who inspired modern palliative care, introduced the term 'total pain' to highlight the multifactorial origins of suffering in terminal disease (Saunders 1964) and Sugden has illustrated this from his own practice (Sugden 2001).

There is a growing acceptance that human existence consists of body mind and spirit, and that health and wellbeing are determined by all of these, individu-

ally and together. Moreover, spiritual care should not be apportioned exclusively to professional clergy, and clinicians should be prepared to engage with their patients on these issues if real needs and morbidity are to be recognised and addressed (Due, 1996).

Whilst there is legitimacy in the concept that spirituality is not always expressed in religious terms, nonetheless adequate spiritual care must acknowledge the possibility of the transcendent relationship with God, and must move beyond mere psychotherapy and attentive listening, to address issues of forgiveness, love and hope (Due, 1999). Psychotherapy itself can and should extend beyond this basic level with the instillation of hope (Yalom 2005) and the principles of love and forgiveness being developed in a holistic approach when required.

Our account vividly demonstrates the reality of ‘total pain’ and the contribution of spiritual and psychological care to its resolution. The importance of a collaborative holistic multidisciplinary team in the care of such a patient is evident. The change in the patient’s life was apparent to the chaplain, clinical staff, and her family. Hostility abated, and she expressed a sense of “living life to the full”, including enjoyment of art and literature. She purposefully attended to a variety of practical affairs, including discussing her own funeral arrangements. She specifically wanted the chaplain, who conducted her funeral, to communicate to the congregation that true fulfilment in her life had indeed been found in Christ.

The extension of suffering beyond the physical may influence the patient’s reaction to social or health care engagement, and sometimes these patients are labelled as ‘difficult’ by clinical staff, as in the case presented here. In our experience, such patients do not receive the same quality of care and attention as others, and can become aware of a reserved or even discourteous attitude amongst carers. This may only serve to exacerbate the problem. The challenge is to consider *why* a patient may be difficult. Careful enquiry into previous life experiences will often reveal one or more causes, and attempts to address these can then be made.

Discussion of spiritual issues is often evaded with patients in hospital, even by clergy, on the premise

that it is a personal and private matter, not to be provoked or coerced by others. The prevailing view seems to be that patients are to be supported in their existing patterns of belief where the matter is discussed at all. However, as this case clearly demonstrates, sensitive exploration of faith and beliefs, balanced with appropriate support and encouragement, is sometimes necessary for effective care.

Moreover, terminally ill patients occasionally wish for a spiritual change, but assume that there is little or no point in contemplating this at such a late stage in life or that, having had little of their devotion earlier in life, God would reject them anyway. Such change in the end stages of life is indeed possible (cf. Matthew chapter 20; Luke chapter 23), and may be perhaps all the more meaningful in the context of impending death.

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