Pain Relief Associated with a Religious Visitation: A Case Report

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A 68-year-old black woman tolerated partial colectomy for resection of a carcinoma with minimal postoperative discomfort and without the need of any analgesia. She attributed her positive experience to the presence of protective angels. Psychologic interviews and testing revealed her to be fully in touch with reality. Her experience, as well as those of similar patients reported in the medical literature, has biological, sociocultural, and psychological components. The role of religious belief in the pain experience has received scant attention, but it constitutes a challenging area for future research.

Physicians, who are granted the power of relieving pain and suffering, frequently debate the wisdom of using this capability, particularly when the mainstay of therapy, the narcotic analgesic, may result in deleterious physiologic and psychologic effects. Marks and Sachar,[1] who examined narcotic dosing in medical patients and related physician attitudes, concluded that "needless suffering" occurred because of misconceptions regarding the addictive potential of such drugs as meperidine. Cohen[2] confirmed these findings in a more recent study of postsurgical patients and nursing attitudes. The opposite situation, the patient who unexpectedly experiences little or no pain in the face of major surgery or illness, has received minimal attention in the medical literature. Yet the person who rejects offered analgesics is equally challenging and perhaps more threatening to the medical profession than is the person who demands such relief. This paper presents such a case, and the multiple factors that can minimize an individual's psychic response to personal pain are analyzed.

Case Report

Mrs. M.J., a 68-year-old black woman, was admitted to the hospital in July 1981 with a chief complaint of dyspnea on exertion and fatigue of one month's duration. She had come for an office consultation on the day of admission and was hospitalized after she was found to have a hemoglobin level of 4.0 g/100 mL and a hematocrit of 11.7 percent. In 1975 she had had a right hemicolectomy for a moderately well-differentiated

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adenocarcinoma of the colon. The tumor had extended almost to the peritoneal surface, although the mesenteric lymph nodes had not been involved. She had done well until February 1980, when she again began to note intermittent hematochezia, but had not brought this to medical attention. She moved from her home in Louisiana to California in March 1981, and the July 1981 hospitalization was her first contact with the medical profession in her new home. Her husband had been seen several times in the Family Practice Center and at the time of her admission had been hospitalized himself for over a month for a cerebral vascular accident complicated by pulmonary emboli and acute renal failure requiring hemodialysis. Mrs. M.J.'s past medical history also included a lumbar compression fracture in 1975, treated with a combination of methandrostenolone, orphenadrine, aspirin, and caffeine (Norgesic Forte); and hypertension, treated with chlorthalidone.

Physical examination was remarkable for pallor of the nail beds and mucosal surfaces, a heart murmur consistent with aortic sclerosis, and a rectal examination revealing blood-streaked stool. Examination of the peripheral blood smear revealed red blood cell morphology compatible with iron deficiency anemia. A chemistry panel was unremarkable, serum iron was 7 μg/100 mL and a total iron-binding capacity was 314 mg/100 mL. Sigmoidoscopy, performed to 15 cm in depth, was normal. Barium enema revealed a 4-cm long lesion of the midsigmoid colon consistent with carcinoma. A scan of the liver and spleen was unremarkable. The patient was transfused to a hemoglobin level of over 10 g/100 mL, and then underwent resection of the sigmoid colon with primary anastomosis under general anesthesia. Pathologic study revealed a grade II adenocarcinoma infiltrating the muscularis layer without lymph node involvement. As part of the patient's preoperative medication, 8 mg of morphine sulphate was given intramuscularly. Postoperatively, 75 mg of meperidine given intramuscularly as needed for pain was ordered but never administered. A review of medication records revealed that the patient received no analgesic medication of any kind throughout her entirely uneventful postoperative course. She was discharged on the seventh postoperative day with her husband still hospitalized in an adjacent room.

After the physicians realized that the patient was requiring no postoperative analgesia, they questioned her regarding her lack of pain. The patient replied that she had minimal discomfort because angels were watching over her and taking care of her. She could see them gathered around her bed, but they did not talk to her. They had humanlike features and were surrounded by a bright glow. She claimed that their comforting presence had nearly eliminated any postoperative pain.

Patient Profile

Mrs. M.J. was born and raised in Shreveport, Louisiana. The patient recalled that during her childhood illnesses she had visions of beings that her mother told her were protective angels. These were luminous beings of small stature that made her feel secure and calm. Her mother died when Mrs. M.J. was six years old; thereafter, she and her seven siblings were raised by her father and grandmother. She married in 1945 and moved to Oakland, California. When a hysterectomy was performed in 1947, she did not see protective angels or any other vision; she explains this by noting that she did not "know the Lord" until 1948. After her second surgical procedure—the partial colectomy for colon cancer in April 1975—she saw protective angels but still needed postoperative analgesics. In November 1975 she was hospitalized for back pain from a vertebral compression fracture and a similar experience occurred: visions of protective angels, but significant amounts of pain.

Psychological Consultation

The Family Practice Center psychologist saw the patient in consultation. The mental status examination revealed her to be cooperative and attentive. She was well groomed and had a relaxed facial expression. There was no noticeable impairment of hearing or vision. Her mood was optimis-

tic and self-confident, particularly when discussing her health and postoperative perceptions. She was alert and displayed no anxiety. Her emotional expression was normal and spontaneous. Her judgment was sound and concentration normal. Her thought processes were intact without evidence of unusual ideation, and there was no evidence of severe perceptual disturbance. She had not had visions of any kind prior to surgery. Her orientation was normal, and her recent and remote memory were unimpaired.

A Minnesota Multiphasic Personality Inventory (MMPI) was administered three months postoperatively, when she had fully recovered. The test revealed normal scores in almost all of the subscales with the exception of slight elevation of the L and Pd scales. These subscales are often mildly elevated in religious people who want to present themselves favorably and to deny human frailties. Other subscales showed good ego strength, good understanding of normal behavioral patterns and societal expectations, and no evidence of bizarreness, psychotic ideation, or delusions of grandeur. The normality of the MMPI confirmed the clinical impression of the reliability of Mrs. M.J.'s account of her experience.

Discussion

A patient experiencing no postoperative pain is unusual but by no means unreported. McMahon and Miller[3] have reviewed the older literature pertaining to the prevalence of this phenomenon. In World War II, Beecher[4] noted that only one third of severely wounded soldiers required narcotic analgesics as opposed to four fifths of surgically wounded civilians. He concluded that a relationship existed between the pain experience and the significance of the wound to the patient. Papper et al[5] found that 25 percent of 108 patients with intra-abdominal or intrathoracic surgery did not complain of pain. More recently, Bond[6] has made similar estimates for the percentage of patients not requiring narcotics.

Woodrow et al[7] reported that pain tolerance decreases with age. Paradoxically, narcotic analgesia is, dose for dose, more potent in the elderly. In a retrospective study of 947 postoperative cancer patients, Kaiko[8] found that elderly patients experienced increased total pain relief after morphine. This result was explained by an increased duration of relief (approximately two hours longer) rather than an increase in the peak of pain relief. Mrs. M.J. received morphine as a preoperative medication, but even accounting for her advanced age, Kaiko's data would suggest that the dose would not have lasted significantly into the postoperative period.

Simple documentation of no or minimal amounts of administered as-needed medication on nursing records is not equivalent to absence of pain. Physicians tend to underorder narcotics in terms of amount and frequency[1]; nurses tend to underadminister the narcotics that are ordered.[2] In the present case, a review of nursing notes revealed that Mrs. M.J. was asked about discomfort repeatedly, and she always denied it. Even when a patient has not solicited or has actually refused prescribed medications, it cannot be assumed that he or she is pain free. Sociocultural influences appear to play a major role in this dichotomy. Zborowski's[9] famous study comparing the pain responses of Americans of Irish, Italian, and Jewish descent with a group he called "Old Americans"* found that the latter group did not outwardly express their pain. They did not wish to be regarded as weak or helpless and, therefore, withdrew when faced with severe pain. This stoicism contrasted with the styles of the three other groups. Kees[10] reported that when compared with the more affluent patient, the patient of low socioeconomic status would be more likely to accept a severe illness as a natural event. McCabe[11] found that the rural Southern black patient was unlikely to complain of pain, even when seriously ill and judged by nursing staff to be in discomfort. The observation of the calm demeanor of Mrs. M.J. as she denied pain and related her vision of protective angels convinced the medical staff that she was not dissembling and actually was experiencing minimal discomfort.

External events and personal characteristics, as well as the patient's cultural background, can

*"Old Americans" were defined as white, native-born individuals, usually Protestant, whose grandparents, at least, were born in the United States and who do not identify themselves with any foreign group, either nationally, socially, or culturally.

influence the individual's appreciation of pain. Armenian et al[12] reviewed the medication records of 246 appendectomy patients who were operated on either before, during, or after the Lebanese Civil War. They observed a significant decrease in narcotic administration concurrent with and continuing after the war. System-related and patient-related factors were implicated to explain the findings. System-related factors included changes in nurses' attitudes and pain assessment in civilian as opposed to military cases. Patient-related factors included possible changes in pain perception due to the stressful war situation. These results have obvious implications for interpreting Mrs. M.J.'s postoperative course; the family was under considerable stress with the simultaneous hospitalizaton of husband and wife. Her husband's suffering may have altered her perception of the meaning of discomfort.

Several aspects of the psychological makeup of the individual have been correlated, not only with postoperative pain, but also with objective measures of healing. George et al[13] prospectively studied these interrelations in patients undergoing oral surgery. They found that severity of pain correlated positively with five predictors: increased expectation of postoperative pain and swelling, increased anxiety about recovery (state anxiety), increased anxiety as a basic personality trait (trait anxiety), increased vigilance as a coping behavior, and increased internal locus of control. Absence of the above five parameters predicted a lesser degree of discomfort. Mrs. M.J.'s religious orientation and her experience of being surrounded by protective angels place her in the personality profile felt by George et al to be best suited for recovery. Her expectations were positively conditioned by her previous uneventful surgery for colon cancer. Her experience of being in the custody of angels over a number of years minimized any trait anxiety. She therefore felt no need to be vigilant and, in fact, never confronted or sought information from her physicians. The angels represented to her a completely externalized and permanent locus of control. Having given her welfare over to them in the past, she was not threatened by other authority figures such as medical personnel.

The role of religious belief in the pain response has received less attention in medical literature than the psychological, sociocultural, and biological factors. McCabe[11] commented on the high prevalence of spontaneous religious expression among groups of hospitalized rural black patients. Experience with Mrs. M.J. demonstrates 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. Instruments that measure the level of religious belief are being used for other research purposes.[14] Application of these methods to surgical populations might elucidate yet another dimension to the clinical challenge of understanding a patient's response to medical intervention.

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