Maciej Wiktor Klimasiński[1], Ewa Baum[2], Katarzyna Wieczorowska-Tobis[1]
[1]Department of Palliative Medicine, Poznan University of Medical Sciences, Poznań, Poland
[2]Department of Social and Human Sciences, Poznan University of Medical Sciences, Poznań, Poland

Spiritual care provided by a physician in a pain management clinic: a bidirectional relationship between chronic non-cancer pain and spirituality

Abstract

Introduction: Recent years have seen a significant increase in research on the relationship between spirituality and chronic disease. This article aims to present the publications and research evidence on this topic and to propose a model for providing spiritual care in pain management clinic.

Methods: The study uses the snowball method. The key source for this article was Professor Christina Puchalski's book entitled *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying*.

Results: Changes occurring in this sphere can take one of three directions. In some patients, spiritual experiences and beliefs may reduce their quality of life (spiritual distress) and even increase pain. In other patients, suffering can cause a complete disappearance of spiritual life. Spirituality can also be developed and help to adapt to illness. This third possibility is what is known as positive spiritual coping. The patient can use their spiritual beliefs and experiences to find resilience and even acceptance in the face chronic pain.

Conclusions: Given the existence of this possibility, the aim of spiritual care will be precisely to restore spiritual well-being to patients who experience spiritual distress. Physicians can provide spiritual care that improves the quality of life by adopting the right attitude towards patients and talking to them about their life story and spiritual beliefs and experiences.

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Keywords: chronic pain, spiritual care, morality, suffering, quality of life

Address for correspondence:
Maciej Wiktor Klimasiński
Department of Palliative Medicine, Poznan University of Medical Sciences, os. Rusa 55, 61–245 Poznań, Poland
e-mail: klimasinski@gmail.com

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Introduction

For practitioners in pain management clinics, it is important to recognize that spirituality can significantly influence the quality of life of chronic pain patients and even the level of pain that they experience [1–3]. In order to conduct an in-depth analysis of these correlations, it is necessary to explain some of the terms used in the English-language literature. The relationship between spirituality and the experience of chronic disease can take one of three directions: it can worsen quality of life, have no effect on it at all, or it can improve quality of life. This study aims to analyze the spiritual transformations that occur in patients with chronic pain. An attempt was made to find answers to the questions: what spiritual beliefs held by a patient can reduce their quality of life? What spiritual experiences can improve quality of life? What are the ways to identify patients in whom spirituality is associated with reduced quality of life? What interventions can be taken to improve their quality of life in this area? What interventions can be done by a clinician in a pain management clinic during a standard visit (that usually does not exceed 30 minutes)?

Methods

The snowball method is one of the literature review techniques widely used in various fields of research. The process begins by identifying a few key articles that are directly relevant to the topic under study. These primary sources are often selected based on their reputation, impact on the investigated field, and number of citations. The bibliographies of these key articles are then analyzed. The aim is to identify other related articles that may provide additional information or perspectives on the topic. The newly identified articles are then assessed for their relevance and quality. Each newly discovered article is analyzed in the context of its bibliography, leading to a further search for other sources. This process is repeated, resulting in a gradual expansion of the scope of literature.

The "snowball" method allows for the discovery of a wide range of literature that might be missed in standard database reviews. It allows the researcher to track how research and theories have evolved over time by analyzing citations and links between articles. It helps identify key authors, research centers, and publications that have had a significant impact on the development of the topic under study. However, the process is time-consuming and requires a high level of scrutiny in the analysis and selection of articles. The quality and relevance of the initial articles are crucial to the effectiveness of the entire process. In medicine, the "snowball" method is particularly useful because a full understanding of the literature is essential for drawing reliable conclusions [4, 5]. A key source for this article was Professor Christina Puchalski's book entitled *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying* [6].

Results

Spiritual dryness

The first variant of the correlation between spirituality and the experience of chronic disease is when the disease leads to reduced attention to spiritual matters. One manifestation of a person's spirituality is faith, which can be lost as a result of experienced suffering. This often leads to withdrawal from religious institutions/groups [7]. According to Farahani et al. [8], if a patient feels that the God they believe in is not responding to their requests for healing, they may feel abandoned by Him. This may be followed by spiritual dryness, especially if the patient is experiencing emotional exhaustion. The other two options can be considered in a non-religious context.

Spiritual distress

The second possibility is that the patients' spiritual beliefs affect them negatively, causing even more distress and reducing their quality of life (negative coping, spiritual distress, spiritual struggle). Illueca et al. [9] report that spiritual distress arises when something threatens the patient's relationship with God or another higher power they believe in. However, the influence of spiritual beliefs on the severity of symptoms (or the occurrence of new ones) does not only apply to patients who are believers. According to Koenig [10], it is natural for patients who have to learn to live with a severe chronic disease to ask existential questions (*e.g.* "Why has this happened to me?"). When such questions become persistent and long-lasting, they will become a separate problem [11]. According to Puchalski et al. [12], spiritual distress occurs when the patient is unable to find or give meaning or significance to their experience of illness. According to Watson et al. [7], authors of a palliative medicine textbook, this phenomenon is described as an inability to accept what is happening, a sense of meaninglessness, injustice, failure, and an identity crisis. In this textbook, spiritual/religious crisis is called "a dark night of the soul" [7]. Lack of inner harmony, conflict with family members and friends, anxiety, anger, disgust (including self-loathing), despair, and helplessness are cited as consequences of spiritual distress [7, 13]. This phenomenon has been shown to reduce life satisfaction and self-esteem, worsen mood and sleep

quality, exacerbate depressive and anxiety symptoms, aggravate post-traumatic stress disorder, and even worsen symptoms of the underlying disease [7, 10, 12–24].

Spiritual well-being

There is also a third possibility — spiritual beliefs may be associated with a certain degree of resilience in the face of illness. If spirituality helps the patient to adapt to their chronic disease (positive coping), they may experience spiritual well-being, despite chronic illness. Spiritual well-being is experienced when a person perceives the world positively, feels inner peace, accepts themselves and their story, is convinced that their life has meaning and purpose, lives in harmony with their values, and builds positive relationships with their environment. In other words, spiritual well-being is the integration of spiritual beliefs into everyday life that results in a good quality of life [10, 25]. According to Southwick et al. [26], resilience is the ability to endure, adapt, return to normality, and function positively in the face of stress or adversities. According to Cassel [27], it is the ability to recover from a loss (instead of sinking into suffering and despair). The author cites an example of a runner who has suffered an irreversible leg injury. He notes that if that runner can never run again, he may compensate for the loss by learning another sport or way of expressing himself and that a similar mechanism can occur in situations such as loss of relationships, social roles, and ability to function. The reason he gives for that is that even though the human body cannot gain a new part to replace the lost one, the human person has the ability to do so.

According to Pargament et al. [17, 28], Puchalski et al. [6, 18], Chatters [15], and Saad et al. [20], positive spiritual coping involves patients using their spiritual beliefs (related to the meaning of life, the meaning of suffering, transcendence) to find strength and comfort and even acceptance in the face of an incurable, severe disease. In this way, they can achieve spiritual well-being and reduce emotional distress and depressive symptoms, and therefore reduce perceived suffering and improve their quality of life [6, 15, 17, 18, 20, 28, 29]. Some authors argue that one form of spirituality — religious resources — can be used as a strategy for the cognitive effort involved in re-evaluating one's story and making it meaningful. In this sense, it is not a passive process and can have a healing effect even in such difficult experiences as the loss of a loved person or an incurable disease [13, 15]. According to Puchalski [6], hope is one of the spiritual mechanisms for coping with progressive loss of health. It is transformed during the disease, because at the beginning patients usually hope that they will recover. Later, when this occurs to be unlikely, they hope to live in peace with their loved ones and/or with God. In contrast, at the end of life, they hope for a peaceful death and life after death.

Positive spiritual coping with illness can even take the form of inner development. Some patients report that their illness has led them to a deeper reflection on the human condition and the meaning of life, strengthened their faith, increased their sense of closeness to God or some other higher power, and even that their life is better after the diagnosis than it was before [14, 30]. Thus, confronting a disease that may lead to irreversible disability or death can open the way to inner healing (regaining inner integrity — restoration of wholeness) [6, 18]. Naturally, illnesses should not be idealized for the mere fact that it can lead to a deeper knowledge of oneself and the meaning of one's life or a change in one's previous beliefs about faith. Even though in Christianity suffering can take on a momentous meaning (it is taught that a patient can link their suffering to the passion of Jesus and offer it to God for various intentions), the Catholic Church emphasizes that pain should always be relieved, which is the professional duty of the physician [31, 32].

The impact of chronic disease on non-religious spiritual experiences can be classified according to the corresponding parts of the definition of spirituality developed by the Polish Society for Spiritual Care in Medicine (Table 1) [33]. To test whether the experience of chronic disease initiated a spiritual transformation, question 11 from the Functional Assessment of Chronic Illness Therapy — Spiritual Well-Being 12-Item Scale (Facit-Sp-12) can be used: "Has the illness strengthened your faith or spiritual beliefs?" [34]. Fuchshuber et al. [35] developed a tool to measure spiritual well-being for patients who believe in God, including statements such as: "My faith gives me a feeling of security"; "I can find satisfaction in intimate conversations with God"; "With God's help I can overcome all my problems" [35]. Similarly, the patient can be asked to what extent they agree with examples of statements regarding non-religious spiritual transformations in illness (Table 1).

It is worth to mention a systematic review by Ferreira-Valente et al. [2], which examined the extent to which levels of religiousness and spirituality are associated with chronic pain. The analysis involved 20 experimental and observational studies. From this, it was found that chronic pain sufferers with higher levels of spiritual well-being tended to have better physical functioning. Most remarkably, no significant association of religiousness with pain, physical functioning, or coping responses was found in chronic

Table 1. The impact of chronic disease on non-religious spiritual experiences*

Examples of patient statements	Spiritual distress		Experience of chronic disease can cause changes in every aspect of non-religious spirituality:		Spiritual well-being	Examples of patient statements
"I am just a burden to others" "My life doesn't make much sense"	Sense of loss of life roles, the meaning of life is difficult to define	←	Spirituality is expressed in the way a person searches for and gives meaning and purpose to their existence	→	Finding meaning and purpose in one's existence	"There are other life roles that I can perform regardless of my limited abilities"
"Why did this happen to me?" "Life is unfair, the world is cruel" "I feel that no one understands me"	Conflict with self, nature, or God, inner struggle, lack of forgiveness (self-forgiveness, forgiving others), isolation from "healthy" people, jealousy, sense of alienation, loneliness	←	Spirituality is expressed in the way a person experiences a connection with themselves, other people, nature, God	→	Inner harmony, forgiveness, sense of being part of a greater whole (connection/closeness to others, nature, God)	"I feel that I am part of a greater whole" "Due to the limitations related to the disease, some relationships have taken on a new depth"
"I am not able to do what I think is right, morally correct"	Limitations related to the disease make the patient start to act contrary to their beliefs	←	Spirituality is expressed in the way a person experiences and interprets the world around them - the person's values, goals	→	Developing new beliefs and goals, acting according to which is possible despite the limitations related to the disease	"Limitations due to the disease have made my beliefs change"
"I cannot accept what has happened to me"	Unwillingness to change, lack of acceptance of the course of the disease	←	Spirituality is expressed in the way a person relates to what transcends them and how they transcend themselves	→	Willingness to change, acceptance of the course of the disease	"Even if the disease progresses I can be happy"

*Explanation and sources in the text

pain sufferers. This supports the hypothesis that the level of religiousness does not directly translate into levels of spiritual well-being in the face of illness [14]. A highly religious person may have difficulty with meaning and purpose of their life, inner harmony, moral stance, relationships with other people, and attitudes towards what transcends them and going beyond their own limitations. In the same way, it is possible for a person who is not religious to experience well-being in all o of these areas.

For this reason, the authors of this article believe that level of spiritual well-being can best be determined using a validated questionnaire that do not refer to specific religious beliefs or practices and have been translated into the Polish language and validated in Polish, such as the Facit-Sp-12 [3]. It is worth noting that there are also proposals to use single screening questions for this purpose. One might ask the patient: "How are you?", bearing in mind that the physician is interested in non-physical symptoms at this moment. Another question to identify spiritual pain is: "Do you lack inner peace or do you need more inner strength?". To draw the patient's attention to their resources, one might ask: "For some people, believing in something or someone gives them a sense of purpose — do you feel this way too? If so: Are there any activities that come to mind that give you peace of mind?" [14, 36].

The purpose of spiritual care

According to many authors, spiritual care involves addressing spiritual pain, being attentive to spiritual issues, alleviating spiritual suffering, and increasing spiritual well-being [19, 23, 37, 38]. Some authors express the purpose of spiritual care more specifically, linking it to support for patients' personal development. Spiritual care is supposed to increase resilience to difficulties, give strength in coping with health challenges, help to pass through the crisis of illness, and restore to wholeness after an injury to personhood [14, 21, 39]. The purpose of spiritual care is described by Puchalski et al. [12] even in terms of inner healing (full integration of all dimensions of the human being). According to Surzykiewicz et al. [22] "one of the key challenges facing medical practitioners is to help people find meaning and acceptance in suffering and chronic illness".

The goals of spiritual care can be grouped according to the respective parts of the definition of spirituality developed by the Polish Society for Spiritual Care in Medicine (PTODM) [33]. In terms of the concept of transcendence — spiritual care aims to enable the patient to see their situation from a new, broader perspective so that they can accept their own limitations and transcend previous ways of functioning [14, 40]. According to Stelcer et al. [41], one of the forms of constructive responses to an existential crisis is reflection on the spiritual dimension of existence, openness to the world, to the full experience of living, and to the sensations that this experience brings. Of course, this is not easy, it requires the patient to leave their comfort zone, and they need support in doing so.

In terms of existential search, if the patient has a sense of meaninglessness in life, the aim of spiritual care would be, for example, to help them find a role that they can fulfill regardless of their physical fitness. According to Zock [42], spiritual care should aim to help individuals become more insightful in their lives. The key question is: "How can an individual regain a sense that their life constitutes a meaningful and comprehensible whole in the face of an ongoing process of change?". According to Potts et al. [43], the patient should be helped to "make sense of their world and their situation in their own way". According to a document issued by the Catholic Church on the ethics of medical professionals [32], the patient expects from the doctor not only adequate medical care but also human support that is capable of making them embrace a vision of life in which they discover the meaning also of suffering and death.

Going further into the definition proposed by PTODM: for a patient who, due to a chronic disease, may experience conflict in relationships — with themselves, with others, with nature, with the sacred [33] — the goal of spiritual care will be to achieve inner harmony, forgiveness, a sense of belonging to a larger whole. Balboni and Balboni [14] write about how a patient experiencing pain can be "brought closer to a transpersonal source of meaning and to the human community that shares those meanings". Potts et al. [43] write about spiritually supporting patients and their families to find connectedness, reconciliation, and peace in ways that are meaningful to them: "Spiritual caregiving is about helping all persons find peace within their own spiritual understanding". Gardner et al. [44] explored the experiences of spiritual care for patients and families in an Australian hospital. In the introduction to their paper, they reported that "spiritual need is met by anything that keeps you in touch with yourself, or connects you with people and ideas that matter, or keeps you going when life seems difficult and the future uncertain". To identify when spiritual care was provided, they asked the patients what made them manage to endure their hospital stay, what supported them, what influenced their well-being, and if they received support in understanding their experience. A summary of the purpose of spiritual care is described in Table 2.

Ways to achieve the purpose of spiritual care

In a paper on the relationship between spirituality and quality of life, the World Health Organisation (WHO) confirms that subjective experiences, beliefs, and expectations influence objective health and functioning in the physical, mental, and social dimensions of life [45]. Spiritual practices can therefore positively influence well-being, improve life satisfaction, evoke positive emotions, and a sense of gratitude, fuel optimism, reduce symptoms of post-traumatic stress disorder, and contribute to recovery from traumatic experiences [22, 46, 47]. Certainly, insufficient provision of spiritual care to patients intensifies their suffering (they report more depressive symptoms and less sense of meaning and peace) [24]. The question then arises: if a physician manages to identify a patient who needs spiritual support, exactly how can they provide it in daily clinical practice, taking into account the various concepts of spirituality and the needs and practices associated with it? [46–48]. Many authors report that the clinician can contribute to reducing the severity of suffering resulting from chronic disease precisely by providing spiritual support. According to many authors, it is possible for the physician to increase the patient's resilience, to help them cope with the crisis of the illness, to help them accept insurmountable limitations, to find meaning in a life burdened by incapacity, and to regain inner harmony. They can achieve this by adopting an adequate attitude towards the patient and talking to them in a specific manner (Table 3). A conversation with the patient on spiritual issues can also be carried out by following the HOPE questionnaire, which has been adapted to Polish conditions [52].

Medical professionals have a special opportunity to support the patient, especially when they confess their most serious complaints, sometimes also revealing their despair and lack of hope, often not revealed to their loved ones. In other words, by establishing a positive therapeutic relationship with the physician, patients can see their life situation from a different perspective and even rediscover the meaning and value of their life [16, 18, 27]. The literature also lists activities that are not elements of spiritual care, which should not be carried out by the physician for moral and ethical reasons, which would most likely worsen

Table 2. Goals of spiritual care in the Pain Management Clinic*

STEP 1 — identification of patients whose spiritual distress contributes to a reduced quality of life		→	STEP 2 — implementation of a non-religious spiritual intervention	→	STEP 3 — a successful intervention improves the patient's quality of life and even reduces the level of pain and improves physical condition	
Spiritual distress	Reduced quality of life					
Sense of loss of life roles, the meaning of life is difficult to define	• Increased stress • Unpleasant emotions • Decreased self-esteem • Decreased satisfaction with life • Worse quality of sleep • Increased depressive and anxiety symptoms • Subjective feeling that symptoms of the underlying disease are more severe	→	Spirituality is expressed in the way a person searches for and gives meaning and purpose to their existence	→	Finding meaning and purpose in one's existence	• Reduced stress • Pleasant emotions • Higher self-esteem • Higher satisfaction with life • Improved quality of sleep • Reduced depressive and anxiety symptoms • Subjective feeling of reduced symptoms of the underlying disease
Conflict with self, nature, or God, inner struggle, lack of forgiveness (self-forgiveness, forgiving others), isolation from "healthy" people, jealousy, sense of alienation, loneliness		→	Spirituality is expressed in the way a person experiences a connection with themselves, other people, nature, God	→	Inner harmony, forgiveness, sense of being part of a greater whole (connection/closeness to others, nature, God)	
Limitations related to the disease make the patient start to act contrary to their beliefs		→	Spirituality is expressed in the way a person experiences and interprets the world around them — the person's values, goals	→	Developing new beliefs and goals, acting according to which is possible despite the limitations related to the disease	
Unwillingness to change, lack of acceptance of the course of the disease		→	Spirituality is expressed in the way a person relates to what transcends them and how they go beyond themselves	→	Willingness to change, acceptance of the course of the disease	

* Explanation and sources in the text

Table 3. Non-religious spiritual interventions

Interventions that a physician can perform in order to increase spiritual well-being (reduce spiritual distress) of a patient	References
Establishing a friendly interpersonal relationship with the patient	[6, 19, 39, 44, 46]
Attentive presence, especially at times the paint is experiencing deep sorrow, showing empathy/compassion	[6, 13, 19, 38, 43, 44, 46, 49, 50]
Treating the patient with due dignity, respecting the fact that everyone is different, listening to their statements/stories — in a special way (active, reflective), especially when they talk about the things most important to them	[6, 13, 19, 38, 43, 44, 46, 49, 50]
Conversation with the patient about their identity, life story, the meaning of life, and metaphysical topics. Facilitating the expression of spirituality. Attempting to understand and validate their worldview, unique beliefs, and values. Identifying resources and needs. Assessing the way in which spirituality influences the patient's experience of the disease. Supporting positive coping (strengthening spiritual resources). Looking for signs of spiritual well-being/spiritual distress can be understood as "conducting a spiritual assessment"	[6, 13, 20, 21, 23, 39, 43, 44, 46, 51]

the spiritual state of any patient: ignoring the presence or words of the patient [37]; a paternalistic approach [37]; automatically suggestion a solution to a spiritual problem [6]; exhibiting prejudice against certain traditions, judging, condemning [6, 19]; engaging in discussions about God or religion [49]; sharing specialized knowledge (in the fields of theology or philosophy) [37]; imposing one's own understanding of the world, one's faith [43].

Many publications confirm that spiritual experiences can allow patients to adapt to their illness, re-evaluate their lives, appreciate reality, and find

Table 4. Non-religious spiritual intervention; designed by the authors of this study [6, 10, 33, 44, 51, 61, 62]

Introduction to Part 1
From the interview I conducted with you, it appears that chronic pain significantly affects: the ability to function/ /work/relax/socialize (delete as appropriate before the intervention). I would like to understand better how pain affects your life, so I will ask some questions about your life story. I will not be judging your answers in any way
The main question for Part 1
Please tell me about your past and how your life has changed because of your illness
Prompt questions for Part 1
What were the most significant events in your childhood, adolescence, early adulthood, and maturity?
What is the most valuable in your life today, what is the story behind it?
How would you describe the meaning of your life?
How do you interpret your illness/what deeper meaning might it have?
How has your illness affected your attitude towards life?
Introduction to Part 2
For some people, spiritual experiences and beliefs significantly influence their experience of chronic disease and coping with it. I would like to find out what this looks like for you. I have full respect for the fact that each person experiences their spirituality in their own unique way (diversity or lack of religious belief)
The main question for Part 2
How would you describe your spiritual life/spiritual world? Has anything changed in this domain because of your illness?
Prompt questions for Part 2
What is spirituality in your opinion?
How does spirituality influence your experience of illness?
How do you express your spirituality? Do you attend any meetings related to spirituality?
Do any particular spiritual beliefs or practices help you cope with your pain?
In what ways could you deepen your spirituality?

new hope despite the crisis in which they have found themselves [53–55]. According to de Walden-Gałuszko [56], it is worth encouraging patients to talk, because if the patient talks about the problems, they will be able to achieve so-called *catharsis*. If they recall life successes and valuable relationships, their self-esteem will be strengthened. According to Antunes and Reis-Pina [57], physicians can provide life-enhancing spiritual care by listening to patients' stories about their lives, bringing back meaningful memories, affirming strengths, and providing support through words of affirmation. According to Stelcer et al. [41] such an intervention aims to capture the inner world of the patient without any interpretive bias. A review of one's life is never 100% satisfactory, so an attitude of forgiveness is of paramount importance. Being able to experience forgiveness from others fosters healing (improves spiritual well-being).

The results of three independent systematic reviews and meta-analyses strongly suggest that spiritual interventions using narrative approaches such as therapeutic life review can significantly reduce depressive symptoms, increase spiritual well-being, and improve quality of life [58–60]. Zhang et al. [61] and Mackinlay et al. [62] describe a similar intervention but call it spiritual reminiscence. It involves asking the patient to share memories and stories from their life, using their own materials such as photographs or diaries. This enables the patient to reflect on the history of their life, recall some experiences, and link them to their current situation. Sometimes this leads to a reinterpretation of some events and finding a deeper meaning in them, such as their impact on inner development. The above-mentioned interventions were conducted once a week for a period of 6 to 26 weeks in small groups. Improvements in spiritual well-being (assessed through the Facit-Sp-12 scale) were demonstrated, and the establishment of new interpersonal relationships was also reported [61, 62]. Taking the patient's spiritual beliefs into account also helps the patient to feel respected, while strengthening the doctor-patient bond, even if the doctor's religious or spiritual values differ from those held by the patient [57]. A new, original protocol for conducting a non-religious spiritual intervention can be found in Table 4.

Discussion

There is a significant limitation to the proposed model — realistically, not every physician can explore their patients' life stories and learn about their individual spiritual beliefs and experiences. Communication skills, such as active listening [36], and especially a willingness to understand what is important to the patient, are necessary to apply the intervention described above. According to Andersen et al. [63], this mainly depends on the physician's interests and beliefs about spirituality. In the opinion of Kapała [40], that kind of openness to others is an attitude that stems from ethical and moral sensitivity (an organized value system that determines the approach to life

problems). In practice, openness manifests itself through understanding and respect for others, the ability to forgive, compassion and empathy, recognizing the needs of others, and striving for their well-being [40]. Not every physician is capable of that. Nevertheless, we suggest that physicians involved in chronic pain management should hand out a spiritual well-being questionnaire to patients and inform those with low spiritual well-being about the options available locally to improve it.

It should be added that the way the healthcare system is organized is not encouraging for patients to open up to medical personnel about their most intimate problems or suffering resulting from the disease. Then again, every physician is bound by the *primum non nocere* principle. Focusing seldomly on the treatment of physical illness, may lead to perform activities that increase the suffering of the patient [27]. Indifferent and cold behavior or an overly professional attitude can easily humiliate patients, increasing their suffering. If a patient with chronic pain leaves a pain management clinic with lower well-being, self--esteem, quality of life than before the visit, it means that training in that area should be improved, or even a request for appropriate guidelines should be issued.

Some physicians may view spiritual issues as a very private aspect of a patient's life. Definitely, a proper therapeutic relationship with patients is based on maintaining boundaries. Those boundaries are the unwritten, mutually understood physical, emotional, social, and spiritual limits of the professional relationship. They are crossed when questions or answers make one party feel uncomfortable [11, 36, 64]. Many physicians avoid discussing spiritual issues, unsure of the patients' reactions [11], or approach the topic with a great distance due to being aware of different spiritual beliefs [65]. According to Koenig [11], 20 years ago, most physicians felt just as uncomfortable asking patients about their sexual activity. Nowadays, such questions are part of the standard medical history in some cases. Physicians have overcome their discomfort through training and experience. Similarly, the more often pain management clinic physicians talk to patients about spirituality, the easier and more natural it will be for them to do so [11]. Huperz et al. [65], report that talking to patients about spirituality was "much easier than expected" for the surveyed physicians.

Additionally, physicians express concerns about providing spiritual care in multi-ethnic settings due to potential religious tensions. There are concerns that talking about spiritual topics might be perceived by patients as imposing certain beliefs on them [57]. It should be emphasized that physicians should avoid proselytizing, persuading a patient to choose one type of spirituality or another, or suggesting religious beliefs. They should only ask about beliefs to get an idea of how the patient's spirituality affects their quality of life and possibly indicate where they could get assistance in this regard. Some authors believe that a physician should never initiate prayer with patients, as this is the role of a clergyman and, secondly, physician-led prayer may be inappropriate for a patient [11, 36, 66, 67]. Other authors point out that if a patient asks the healthcare worker to pray with them, the request may be fulfilled [68]. It should also be noted that listening to the existential problems of a patient is a major challenge for a physician. A physician is used to offering solutions to problems raised by patients. Saying "I would think differently if I were you" will not reduce the patient's suffering at all. In contrast, showing patience and compassion can make a patient feel less alone and experience peace and hope [57].

As discussed above, non-believers have a spiritual life related to their values and understanding of the world. Despite that, some authors emphasize that spirituality must always involve the recognition of the existence of some kind of force beyond man. Typically transcendent experiences assume the possibility of an individual establishing a two-way relationship with that higher power and finding hope and a deeper meaning of life, even in the face of the most difficult circumstances [41]. However, when providing spiritual care, a physician cannot expect a patient to change their beliefs about whether a higher power exists or not. On the contrary, a pain management clinic physician is supposed to focus their energy to learning about and respecting their patient's individual beliefs. A physician may analyze with a patient which of their beliefs may worsen their well-being. A certain compromise may be to invoke universal values, such as love, which transcend man. Love, as a fundamental aspect of human experience, is independent of individual spiritual or religious beliefs.

Some physicians believe that incorporating any model of spiritual care would take too much time during the patient-physician encounter [19]. To take this into consideration, it should be firstly said, that the patient can fill in the spiritual well-being questionnaire in the waiting room, before the appointment or even online at home, a few days before the visit. Secondly, the assessment does not have to take place at every visit [11]. It is recommended to perform the assessment during the first visit, after a long break in care, or in the case of significant changes. Thirdly, when a patient's spiritual beliefs significantly reduce their quality of life, they should be referred to a chaplain. In the following cases, a physician should also

recommend a meeting with a chaplain as a spiritual specialist: when a patient wants to have a longer conversation about spiritual problems than possible during a medical appointment or when a patient asks questions about religion [6, 16]. There is an international consensus that spiritual care should be based on an interprofessional, multidisciplinary model that includes people with specialized training in that area [57]. In addition to a deep conversation, a chaplain can also provide: texts to read, a place for quiet prayer and religious rituals. The whole-life confession practiced in Catholicism can be compared to life review therapy [41]. Henderson et al. [69], studied the willingness of outpatients to use the services of a chaplain in Durham, USA. Most patients expressed a desire for support from a chaplain when they needed someone to listen to them or were looking for a companion to pray with. Naturally, the more religious the patients, the more likely they are to ask to see a chaplain. This is of great importance because, as demonstrated above, undertaking religious practice will not have a positive impact on the spiritual well-being of every person. This would be an overestimation of the impact of religion on health and would lead to the erroneous conclusion that all patients should practice it [15].

Barriers to the provision of spiritual support by physicians often include a lack of adequate education on the subject [11, 19, 36, 70]. There is a general need for adequate training of healthcare professionals so that they can respond to the spiritual needs of patients. One source of knowledge in that field is the White Paper of the European Association for Palliative Care (EAPC) [71]. Specific areas of education include, *e.g.*, ensuring that spiritual care is understood as more than just religious care, learning to talk about spiritual issues, fostering understanding, respect, and appreciation of the diversity of spiritual beliefs and values of patients of different cultures and traditions. It is highly significant that spiritual care courses for physicians have begun to include the spiritual well-being of medical personnel, especially as a response to the growing issue of professional burnout. Physicians also need to feel that their lives are full of meaning, depth, and valuable relationships so that at the end of their life path they can say "I had a good life". Thus, non-religious spiritual activities, such as enhancing physicians' self-awareness, are part of spiritual care education [19, 72].

Many studies emphasize that physicians' lack of awareness of their own spirituality is a major barrier for them to provide spiritual support [36, 57]. Presumably, some physicians may never have engaged in in-depth spiritual development. Discussing such a topic with patients may, in that case, contribute to an internal conflict related to previous contact with various forms of spirituality, including religion. Some may fear that patients will ask them about their spirituality and would not be sure what to say [11]. Thus, becoming aware of one's spirituality is a prerequisite for providing spiritual care, making it easier to talk about someone else's experience. For a physician to explore their spirituality, they can answer the following questions: "What makes my life and my work meaningful?"; "What values and beliefs are fundamental in my life?"; "Do I recognize the existence of some kind of force that transcends me?"; "Do I have beliefs of a spiritual nature that help me cope with stress?" [41]. The literature on the subject emphasizes insufficient spiritual support for medical personnel [19]. For that reason, participants in spiritual care courses are encouraged to develop and maintain a program of spiritual self-care, which includes paying attention to the purpose and meaning of their life and work. One of the indicators to measure the quality of spiritual care is whether a facility organizes open events for personnel related to spirituality, such as meditation or support groups [47].

Also, the very provision of medical care can be treated as a spiritual practice. Patients' sharing of their suffering can develop the inner goodness in those who care for them: sensitivity, empathy, gentleness, kindness, and even love. Caring for patients requires going beyond one's frame of mind and helps to realize that we are all exposed to loss, disease, and suffering. This, in turn, can contribute to a deeper understanding of one's own values and goals. A physician without a spiritual background may have difficulty facing the suffering of chronic pain and establishing an honest relationship with a pain management clinic patient. And it is that therapeutic relationship that proves to be healing, not only for a patient but also for a physician. It can be a source of satisfaction and fulfillment and protect against professional burnout. Its absence, especially in such a demanding environment, can quickly lead to dissatisfaction and emotional exhaustion [6, 11, 36, 41, 57, 73]. This is confirmed by the first author of this publication, who rediscovered the value of his work by conducting a pilot implementation of the designed model.

To address all abovementioned limitations the developed model should be supplemented by preparing the physician to provide spiritual care and also a possibility to refer pain management clinic patients to chaplains. Then, using the general suggestions regarding spiritual care, all clinic patients should be given information about the current model, especially the basic competencies of a physician in the field of spirituality and the specialized competencies of a chaplain.

At a later stage, according to an Australian document developed by the Healthcare Chaplaincy Network and the Spiritual Care Association, referred to by Krajnik [46], the quality of spiritual care can be measured through the use of appropriate indicators: percentage of patients whose spiritual needs were assessed using a validated tool; percentage of patients who confirmed that they were offered a conversation on spiritual topics; percentage of medical records related to spiritual well-being assessment and interventions; percentage of patients who confirmed improved spiritual well-being after receiving spiritual care [46, 74].

Conclusions

The following assumptions were made to develop a model of non-religious spiritual care in a pain management clinic:

1. The impact of spiritual beliefs on the experience of chronic disease can take one of three forms:
   a. a chronically ill patient experiences spiritual distress (their experience and beliefs about the four non-religious aspects of spirituality may further reduce their quality of life and even intensify their pain experience);
   b. spirituality does not affect the experience of disease in any way;
   c. spirituality helps the patient adapt to the chronic disease (spiritual well-being increases their quality of life).
2. To assess which one of the above scenarios occurs in a particular patient, the Facit-Sp-12 tool can be used.
3. The purpose of spiritual care is to reduce spiritual distress/increase spiritual well-being, which means confirming the meaning and value of life, helping to accept the limitations resulting from an incurable chronic disease, achieve internal harmony and a sense of belonging to a larger whole.
4. To achieve that goal, an intervention that involves talking with the patient about their life history and spirituality should be implemented.

Spiritual care is an essential component of healthcare in a pain management clinic with proven clinical effectiveness. The process described above outlines the development of a model in which a physician treating patients with chronic pain conducts a basic assessment of spiritual well-being and a brief intervention. This involves talking to patients about their life story and raising the topic of spirituality. Spirituality in a non-religious sense includes changes caused by the disease in the existential, relational, moral, and transcendental areas [33]. Even when a complete recovery is not possible, there is always a chance for "healing" and improving the quality of life by showing respect, kindness, and compassion to the patient. This applies equally to aging, which all patients and physicians experience. The Collegium Medicum of the Nicolaus Copernicus University (CM UMK) in Bydgoszcz implements a program that helps the participants to increase their self-awareness of their spirituality [52]. It is necessary to develop a consultation path for patients with spiritual distress and involve appropriately prepared chaplains, as well as to introduce training in the field of spirituality at other medical universities in Poland.

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Conflict of interest
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The Supplementary Material for this article (Table 4 in Polish: Designed by the study authors, non-religious spiritual intervention) can be found online at: https://journals.viamedica.pl/palliative_medicine_in_practice/article/view/100864.

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