MELITA THEOLOGICA
Journal of the Faculty of Theology
University of Malta
64/1 (2014) 75–99

* Donia Baldacchino
and Aaron Tonna

The Religious Perspective of Suffering in Heart Attack: From "mystery" to the "Mystery"

"State of the Art"

Heart attack is an acute life threatening illness whereby the heart muscle is deprived of blood circulation which affects the normal functioning of the individual. If the heart muscle does not recover by time, chronic heart disease will develop, which impairs the individual's holistic quality of life.[1] However, research demonstrates that religiosity may change individuals' reaction to life challenges such as acute and chronic illness.[2]

In the acute phase of heart attack clients may feel vulnerable due to perceived

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* Donia Baldacchino is a Senior Lecturer at the Faculty of Health Sciences, University of Malta; Visiting Fellow at the University of Glamorgan, Pontypridd, Wales; and Adjunct Faculty Member, Johns Hopkins University, Maryland, USA. Aaron Tonna is a staff nurse at the Medical Ward, Mater Dei Hospital, Malta.

[1] Ellen Gould White, Luis Munilla and Charles E. Wheeling, *Finding Peace Within* (Philadelphia: Inspiration Books East, 1989); Mary T. Quinn Griffin et al., "Spirituality and Well Being among Elders: Differences between Elders with Heart Failure and those without Heart Failure," *Clinical Interventions in Aging* 2, no. 4 (2007): 669-765; Lillan Shoths Brunner et al., *Brunner & Suddarth's Textbook of Medical-Surgical Nursing,* 10th ed. (Philadelphia: Lippincott Williams & Wikins, 2004).

[2] Hayley S. Whitford, Ian N. Oliver and Melissa J. Peterson, "Spirituality as a Core Domain in the Assessment of Quality of Life in Oncology," *Psychology-Oncology* 17, no. 11 (2008): 1121-1128; David E. Vance, Tom C. Struzick and Toyav V. Russel, "Spiritual and Religious Implications of Aging with HIV: A Conceptual and Methodological Review," *Journal of Religion, Spirituality & Aging* 19, no. 3 (2007): 21-38; Idethia Harvey, "Self-Management of a Chronic Illness: An Exploratory Study on the Role of Spirituality among Older African American Women," *Journal of Women & Aging* 18, no. 3 (2006): 75-88.

loss of health, with accompanying feeling of stress and frustration.[3] Thus, individuals may question God for their suffering.[4] However, individuals also become aware of their mortality, and so they tend to realise the preciousness of life which might have previously been taken for granted.[5]

Critical incidence of heart attack triggers the individuals to re-evaluate their life and attempt to return to their life values.[6] Feeling helpless in their vulnerable state, irrespective of whether they having been practising their religion or not, individuals may turn to God for empowerment to cope with their limited health while strengthening their faith.[7] This may be done through various ways, such as personal or community prayer, and reading of inspirational reflective statements.[8] Thus, self-transcendence enables the individual to go beyond oneself to search for the sacred source /God Almighty/Wholly Other to be helped to cope with the current crisis situation.[9] This process may yield spiritual growth and resignation to life events.[10] In contrast, negative perceptions of God, such as considering one's heart attack as a punishment from God, or not coming to

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[3] Doris S.F. Yu and David R. Thompston, "Commentary on Kristofferzon M-L, Löfmark R & Carlsson M (2007); Striving for Balance in Daily Life: Experiences of Swedish Women and Men shortly after a Myocardial Infarction, Journal of Clinical Nursing 16, 391-401," *Journal of Clinical Nursing* 17, no. 8 (2008): 1105-1106; K.Ginzberg, Z. Solomon and A. Bleich, "Repressive Coping Style, Acute Stress Disorder and Post-Traumatic Stress Disorder after Myocardial Infarction," *Psychosomatic Medicine* 64, no. 5 (2002): 748-757.

[4] Donia Baldacchino, "Long-Term Causal Meaning of Myocardial Infarction," *British Journal of Nursing* 19, no. 12 (2010): 774-781; Scott A. Murray et al., "Exploring the Spiritual Needs of People Dying of Lung Cancer or Heart Failure: a Prospective Qualitative Interview Study of Patients and their Carers," *Palliative Medicine* 18 no. 1 (2004): 39-45.

[5] Jane Margaret Hutton and Sarah Jane Perkins, "A Qualitative Study of Men's Experience of Myocardial Infarction," *Psychology, Health & Medicine* 13, no. 1 (2008): 87-97.

[6] Donia Baldacchino, "Myocordial Infarction at Turning Point in Meaning in Life over Time," *British Journal of Nursing* 20, no. 2 (2011): 107-114.

[7] Cheryl Delgado, "Sense of Coherence, Spirituality, Stress and Quality of Life in Chronic Illness," *Journal of Nursing Scholarship* 39, no. 3 (2007): 229-234.

[8] Maryjo Prince-Paul, "Relationships among Communicative Acts, Social Well-Being and Spiritual Well-Being on the Quality of Life at the end of Life in Patients with Cancer Enrolled in Hospice," *Journal of Palliative Medicine* 11, no. 1 (2008): 20-25.

[9] Elaine J. Yuen, "Spirituality, Religion, and Health," *American Journal of Medical Quality* 22, n. 2 (2007): 77-79: Lisa M. Lewis et al., "African American Spirituality: A Process of Honouring God, Others, and Self," *Journal of Holistic Nursing* 25, no. 1 (2007): 16-23; Margaret A. Murkhardt and Mary Gail Nagai-Jacobson, *Spirituality: Living our Connectedness* (Albany, NY: Delmar 2002).

[10] Renè Van Leeuwen et al., "Aspects of Spirituality Concerning Illness," *Scandinavian Journal of Caring* 21, no. 4 (2007): 482-489.

terms with one's illness, may yield weakness in one's faith and spiritual distress.[11] For individuals who experience spirituality within the context of religion, loss of faith weakens their holistic coping capabilities.[12] Individuals with religious discontent have found more likely to develop spiritual distress, lower quality of life and lower self-efficacy.[13] This may be because of these individuals' religious struggle whereby they realise the perceptions of sinfulness, self-blame and guilt, that may contribute towards spiritual distress which interferes a holistic quality of life.[14] Conversely, spirituality may influence illness perception whereby a "strong spiritual connection may improve one's sense of satisfaction with life or enable accommodation to disability."[15]

The chronic phase of a heart attack may negatively influence clients' quality of life due to their perceived loss of control over their recovery process, and this may lead towards hopelessness and depression.[16] However, research demonstrates that individuals' faith may be a resource of strength in chronic heart disease,[17] and this

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[11] Joy Penman, Mary Oliver and Ann Harrington, "Spirituality and Spiritual Engagement as Perceived by Palliative Care Clients and Care Givers," *The Australian Journal of Advanced Nursing* 28, no. 4 (2009): 29-35; Terry Gall and Karen Grant, "Spiritual Disposition and Understanding Illness," *Pastoral Psychology* 53, no. 6 (2005): 515-533; Betty R. Ferrell et al., "Meaning of Illness and Spirituality in Ovarian Cancer Survivors," *Oncology Nursing Forum* 30, no. 2 (2003): 249-258; Rebecca Hodgkinson and Helen Lester, "Stresses and Coping Strategies of Mothers Living with a Child with Cystic Fibrosis: Implications for Nursing Professionals," *Journal of Advanced Nursing* 39, no. 4 (2002): 377-383.

[12] Debora Mariano Ondeck, "Religion and Spirituality," *Home Health Care Management Practice* 14, no. 3 (2002): 231-232; Donia Baldacchino and Peter Draper, "Spiritual Coping Strategies: A Review of the Nursing Research Literature," *Journal of Advanced Nursing* 34, no. 6 (2001): 833-841; Donia Baldacchino, Aru Narayanasamy and Donna M. Mead, eds., *Spiritual Care: Being in Doing* (Malta: Preca Library, 2010).

[13] Joan F. Miller, Timothy R. McConnell and Troy A. Klinger, "Religiosity and Spirituality: Influence on Quality of Life and Perceived Patient Self-Efficacy among Cardiac Patients and their Spouses," *Journal of Religion & Health* 46, no. 2 (2007): 299-311; Roger D. Fallot et al., "Spirituality and Religion in Recovery: Some Current Issues," *Psychiatric Rehabilitation Journal* 30, no. 4 (2007): 261-270;

[14] Karolymm Siegel, Stanley Anderman and Erich Schrimshaw, "Religion and Coping with Health Related Stress," *Psychology & Health* 16, no. 6 (2001): 631-653.

[15] Cheryl Delgado, "A Discussion of the Concept of Spirituality," *Nursing Science Quarterly* 18, no. 2 (2005): 157-162.

[16] Lucy Selman at al., "Psychological, Social and Spiritual Distress at the End of Life in Heart Failure Patients," *Current Opinion in Support & Palliative Care* 1, no. 4 (2007):260-266; Jennifer Larsen et al., "Depression in Women with Heart Disease: The Importance of Social Role Performance and Spirituality," *Journal of Clinical Psychology in Medical Settings* 13, no. 1 (2006): 39-45.

[17] Craig D. Blinderman et al., "Symptom Distress and Quality of Life in Patients with

was found to help them cope and adapt to the consequences of their illness,[18] decrease depression, foster well-being, and enhance quality of life.[19] Thus, faith appears to be a coping mechanism, which together with social support, fewer physical symptoms, and financial stability may enhance the quality of life in chronic illness.[20] Physical limitations in chronic heart disease may inhibit attendance of church services with negative implications. This is because church attendance may strengthen intrinsic religious beliefs through community prayer which helps clients live coherently with their beliefs. Additionally, extrinsic religiosity may be enhanced when individuals identify themselves with a social group[21] through which they may be supported in their illness.[22] In later stages of chronic heart disease, individuals with a heart attack become more concerned with their physiological symptoms, such as difficulty in breathing and swollen limbs, which seem to distract individuals from prayer and meditation.[23]

The religious perspective in illness could be influenced by various demographic factors. Females,[24] old age,[25] and those with a lower level of education[26] were

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Advanced Congestive Heart Failure," *Journal of Pain Symptom Management* 36, no. 6 (2007): 594-603.

[18] David C. Baker, "Studies of the Inner Life: The Impact of Spirituality on Quality of Life," *Quality of Life Research* 12, no. 1 (2003): 51-57; Judy Kaye and Senthil Raghavan, "Spirituality in Disability and Illness," *Journal of Religion & Health* 41, no. 3 (2002): 231-242;

[19] Delgado, "Sense of Coherence," 229-234; Larsen et al., "Depression in Women," 39-45.

[20] David Bekelman et al., "Spiritual Well-Being and Depression in Patients with Heart Failure," *Journal of General Internal Medicine* 22, no. 4 (2007): 470-477; Michelle M. Rowe, and Richard G. Allen, "Spirituality as a Means of Coping with Chronic Illness," *American Journal of Health Studies* 19, no. 1 (2004): 62-66; Kieren Faull et al., "Investigation of Health Perspectives of those with Physical Disabilities: The Role of Spirituality as a Determinant of Health," *Disability & Rehabilitation* 26, no. 3 (2004): 129-144.

[21] Gordon W. Allport and J. M. Ross, "Personal Religious Orientation and Prejudice," *Journal of Personality & Social Psychology* 5, no. 4 (1967): 432-443.

[22] Harold G. Koeing, "Religion, Congestive Heart Failure, and Pulmonary Disease," *Journal of Religion & Health* 41, no. 3 (2002): 263-278; Margaret M. Poloma and B. F. Pendleton, "The Effects of Prayer and Prayer Experiences on Measures of General Well-Being," *Journal of Psychology & Theology* 19, no. 1 (1991): 71-83.

[23] Sonya R. Hardin, Leslie Hussey and Linda Steele, "Spirituality as Integrality Among Chronic Heart Failure Patients: A Pilot Study," *The Journal of Rogerian Nursing Science* 11, no. 1 (2003): 43-53.

[24] Donia Baldacchino, "Anxiety, Depression and Spiritual Well-Being of Maltese Patients with Myocardial Infarction," (Ph.D. diss., University of Hull, 2002).

[25] Glayds Black, et al., "The Relationship between Spirituality and Compliance in Patients with Heart Failure," *Progress in Cardiovascular Nursing* 21, no. 3 (2006): 128-133.

[26] WHOQOL SRPB Group, "A Cross-Cultural Study of Spirituality, Religion, and Personal Beliefs as Components of !uality of Life," *Social Science & Medicine* 62, no. 6 (2006): 1486-1497.

found to have higher levels of religiosity which were associated with an enhanced quality of life. However, irrespective of participants' demographic data, the life threatening illness of an acute heart attack generated a feeling of self-insufficiency in clients, which triggered in them a higher religiosity and a return to God for empowerment.[27]

Aim

The perceived suffering of individuals may be different during the acute and chronic phases of a heart attack. Existing research on clients with a heart attack has been mainly conducted across the immediate acute phase and the first three to twelve months of recovery. This research has generated inconsistent findings on clients' experiences of suffering, which might have been due to methodological factors such as the use of cross-sectional research design, and the sole collection of quantitative data which carries limitations in exploring the subjective variables of the religious and/or spiritual dimensions of suffering in illness. These research gaps were addressed by this longitudinal descriptive exploratory study which has collected in-depth data across the first five years of recovery from the onset of the heart attack. Therefore, in order to identify possible fluctuations across time, and provide in-depth data about the perceived religious perspective of suffering, this longitudinal study aims to explore the religious perspective of the *mystery of suffering* in clients with a first heart attack, both in the immediate acute phase and across the first five years of recovery.

The Christian Perspective of the Mystery of Suffering

Suffering is derived from the Latin term *passio /dolor* which means "undergo pain or grief or damage or disablement";[28] to struggle and to endure.[29] The dimensions of the concept of suffering embrace the following: something negative or evil that besets a person (pain, agony, torment); something a person has to live with and to which a person is subjected (illness, symptoms, disability); a struggle; something constructive or meaningful that drives one forward; a reconciliation; compassion, that is, to suffer with and for someone else; an expression of something that people lack.[30] Thus, the concept of

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[27] Baldacchino, "Anxiety, Depression and Spiritual Well-Being."

[28] *Concise Oxford Dictionary of Current English,* 5th ed. (Oxford: Clarendon Press, 1964), s.v. "suffer."

[29] Katie Eriksson, *The Suffering Human Being* (Chicago, Ill.: Nordic Studies Press, 2006).

[30] Ibid.

suffering consists of both negative and positive dimensions in which power and joy are identified in both research[31] and the Bible: "I can speak with the greatest frankness to you; ..... in all our hardship, I am filled with encouragement and overwhelming with joy."[32] But "in so far as you share in the sufferings of Christ, be glad, so that you may enjoy a much greater gladness when his glory is revealed."[33]

Thus, when suffering is given meaning and purpose, positive outcomes would result stating: "Suffering and joy are inextricably joined with one another."[34] "Suffering receives meaning ... when you can actualise the person's highest task, to be for or to be in God's service for someone else."[35]

This is witnessed by Christ who fulfilled his mission of salvation by suffering which was completed by the resurrection.[36] In the process of his suffering at Gethsemane Jesus prayed: "For you everything is possible. Take this cup away from me. But let it be as you, not I, would have it."[37] Jesus first demonstrated an act of faith in God Almighty. He then prayed that if it were possible his mission on earth would be fulfilled without suffering. However, he declared that he was ready to align Himself with the will of God.

Research demonstrates that irrespective of the demographic characteristics, individuals with heart attack may question their suffering by asking, "Why me?" This may be due to the stressful situation caused by the illness, uncertainties in life, fear of death, and the need to change lifestyle.[38] St George Preca contends that original sin jeopardised God's plans, because human creatures were not meant to undergo suffering or to die.[39] Consequently, since Christ has experienced suffering in accepting death on the cross[40] as a means of salvation, Christians are also expected to experience suffering during their lives.[41] Hence,

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[31] Harold G. Koenig, Verna Benner Carson and Dana E. King, *Handbook of Religion and Health,* 2nd ed. (Oxford: Oxford University Press, 2012); Baldacchino, "Anxiety, Depression and Spiritual Well-Being."

[32] 2 Cor. 7: 3-4 (New Jerusalem Bible).

[33] 1Pet. 4:12-13 (NJB).

[34] Eriksson, *The Suffering Human Being,* 26.

[35] Ibid, 42-43.

[36] The Catholic Church, *Catholic Church Catechism* (Malta: Media Centre, 1995).

[37] Mk 14:36 (NJB).

[38] Baldacchino, "Long-Term Causal Meaning," 774-781; Geffrey A. Albaugh, "Spirituality and Life-Threatening Illness: A Phenomenological Study," *Oncology Nursing Forum* 30, no. 4 (2003): 593-598.

[39] Gorg Preca, *Il-Pagni ta' Swor Sofia,* 2nd ed. (Malta: Preca Library, 1995), 11: Lecture no. 2.

[40] Phil. 2:8 (NJB).

[41] Gorg Preca, *Il-Kunvent tal-Krucjati,* 2nd ed. (Malta: Preca Library, 1994), 52: Cella 23.

it is recommended that one should endure patiently one's suffering by aligning oneself with the will of God.[42]

Suffering has been considered as mysterious, as shown by the contradictions in the sacrifice of Abraham's son[43] and the experience of Job's various sufferings through which he persevered whereby "in all this misfortune Job uttered no sinful word."[44] Nevertheless, Job's suffering was very painful: "But the very things my appetite revolts at are now my diet in sickness. Will no one hear my prayer, will not God himself grant my hope?"[45] Hence, suffering may be appraised as exceeding individuals' coping abilities, as shown by various Psalms that demonstrate the incessant sobbing of the sufferer who turns to God for help: "Have pity on me, Yahweh, for I am fading away. Heal me, Yahweh, my bones are shaken, my spirit is shaken to its very depths. But you, Yahweh...how long?"[46]

The Old Testament outlines the perceived relationship between suffering and punishment from God, as demonstrated by Job.[47] However, Pope John Paul II emphasised the innocence of Job and God's love.[48] Hence, suffering is not associated with God's punishment and is to be accepted as a mystery.[49] Similarly, in the New Testament, Christ consistently addressed this misconception by educating people on the distinction between physical illness and its relationship with the negative meaning of suffering. While denying the misconception of suffering, Christ also identified the possible benefit of suffering when individuals appraise it in the light of faith as exclaimed by St Paul: "We are well aware that God works with those who love Him, those who have been called in accordance with His purpose, and turns everything to their good."[50] Since suffering is a mystery, the use of faith in searching and finding meaning in one's mysterious suffering may be a resource of personal strength and enhanced coping.[51] This act of faith may lead the person to acknowledge God's actions as ultimately conducive to man's benefits.[52]

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[42] George Preca, *A Spiritual Directory,* 2nd ed. (Malta: Preca Library, 1997) 56: Dir. 312.

[43] Gen. 22 (NJB).

[44] Job 1:10 (NJB).

[45] Job 6: 7-8 (NJB).

[46] Ps. 6: 2-3 (NJB).

[47] Job 1: 11 (NJB).

[48] Pope John-Paul II, *On the Christian Meaning of Suffering: Apostolic Letter: Salvifici Doloris.*

[49] M Bonello, "Il-Problema tat-Tbatija u t-Tjubija ta' Alla," *Spiritwalità* 23, no. 156 (2011): 17-22.

[50] Rom. 8:28 (NJB).

[51] Donia Baldacchino et al., "Psychology and Theology Meet: Illness Appraisal and Spiritual Coping," *Western Journal of Nursing Research* 34, no. 6 (2012): 818-847.

[52] Gorg Preca, *Is-Santwarju tal-Volontà ta' Alla,* 2nd ed. (Malta: Preca Library, 1996), 32-36.

This is shown by the purpose of Christ's course of suffering, that is, the reconciliation of the world with God, which was fulfilled through the resurrection. Hence, positive outcomes may be derived from suffering. This is consistent with the call to Christians to detach themselves from their wealth and live their suffering, supported by Christ: "Anyone who wants to save his life will lose it; but anyone who loses his life for my sake will find it."[53]

While referring to sinners who transformed themselves into saints, supported by the reality of their life experiences, St George Preca proposes that suffering may be a resource of learning about the essence of life and eventually the need to give priority to life values.[54] Other benefits derived from suffering are, an ability to empathise with other people's suffering; awareness about the presence of God in personal suffering; building and maintaining a relationship with God; and awareness about God's plan for the individual based on love and consciousness about life after death, which may enhance hope in illness and the burdens of life.[55] Eventually, suffering may yield positive outcomes:

> Let us exult, too, in our hardships, understanding that hardship develops perseverance, and perseverance develops a tested character, something that gives us hope, and a hope which will not let us down, because the love of God has been poured into our hearts by the Holy Spirit which has been given to us.[56]

However, resistance to suffering in life may weaken one's faith and may lead to spiritual distress.[57] While remembering that "God's yoke is easy and my burden is light. Come to me, all you who labour and are overburdened, and I will give you rest,"[58] a relationship with God and a turning to Him for help may relieve suffering. Additionally, giving meaning and purpose to suffering may help individuals to endure their suffering peacefully: "It makes me happy to be suffering for you now, and in my own body to make up all the hardships that still have to be undergone by Christ for the sake of his body, the Church."[59] Eventually, suffering will be followed by the resurrection as experienced and promised by

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[53] Matt. 16: 24-25 (NJB).

[54] Preca, *A Spiritual Directory,* 56: Dir. 312.

[55] Pope Benedict XVI, *Saved in Hope: Encyclical Letter Spe Salvi* (Kerala: Carmel International, 2007); Kaye A. Herth and John R. Cutcliffe, "The Concept of Hope in Nursing 3: Hope and Palliative Care," *British Journal of Nursing* 11, no. 4 (2002): 977-983.

[56] Rom. 5:3-5 (NJB).

[57] Bonello, "Il-Problema tat-Tbatija," 7-13.

[58] Matt.11:29-30 (NJB).

[59] Col. 1, 24 (NJB).

Christ: "I have told you all this so that you may find peace in me. In the world you will have hardship, but be courageous: I have conquered the world."[60]

Theoretical Framework

To enable meticulous interpretation of the mystery of suffering as perceived by clients who experienced a heart attack, this study has adopted two theories, namely the "Theoretical Model of Causal Pathway for Mental Health, based on Western monotheistic religions (Christianity, Judaism, and Islam)"[61] which supports the seminal theory of "The Idea of the Holy: The *Numinous* Experience."[62]

The Idea of the Holy: The *Numinous* Experience[63]

Rudolph Otto was a German Christian theologian (1868-1937) who conducted phenomenological research studies on monotheistic religions. His book, *The Idea of the Holy - Das Heilige*, published in 1917, and translated into English in 1923 and 1950, discusses the common denominator of religions, referred to as the non rational factor. *Holy* incorporates the behavioural domain and the rational factor of the individual's religion. The behavioural/ethical domain is manifested by righteousness, and adherence to moral values, such as obeying the commandments and leading a good life. The rational factor refers to the conceptual beliefs of a specific religion.

In the monotheistic religions, that is Christianity, Judaism and Islam, the experience of the Holy is considered as the innermost core, the living force of the individual.[64] This common factor is known as the *numen* in Latin, composed of "the Holy" without its moral and rational factors. Therefore, the *numinous* experience is a complex feeling of personal nothingness which is unique to each individual person.

The feeling of personal insufficiency instils in a person a strong yearning to reach out to God, according to the individual's respective religion. This is evidenced by St Augustine who in his confessions states: "My soul longs to find refuge in you oh Lord. I shall find peace in you alone."[65]

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[60] Jn 16:32-33 (NJB).

[61] Harold G. Koenig, Michael E. McCullough and David B. Larson, *Handbook of Religion and Health* (Oxford: Oxford University Press, 2001); Koenig, Carson and King, *Handbook of Religion and Health*.

[62] Rudolf Otto, *The Idea of the Holy: An Inquiry into the Non-Rational Factor in the Idea of the Divine and its Relation to the Rational* (London: Oxford University Press, 1950).

[63] Ibid.

[64] Ibid.

[65] Augustine, *Confessions,* ed. Ben O'Rourke (London: Darton, Longman & Todd, 2013).

The *numinous* experience exists as an innate capacity, so it can be induced or awakened by the individual's life experiences. Following the individual's initiative to turn towards God, this voluntary experience is taken over by the supreme power,[66] resulting in empowerment. Hence, the *numinous* experience is not only "the psychological process but its object, the Holy."[67] Consequently, the *numinous* experience encompasses the *numinous* object and the *Mysterium* which is explained as follows:

> Taken indeed, in its purely natural sense, *mysterium* would first mean merely a secret or a mystery in the sense of that which is alien to us, uncomprehended and unexplained; and so far *mysterium* is itself merely an ideogram, an analogical notion taken from the natural sphere, illustrating, but incapable of exhaustively rendering, our real meaning. Taken in the religious sense, that which is "mysterious" is – to give it perhaps the most striking expression – the "Wholly Other"..., that which is quite beyond the sphere of the usual, the intelligible, and the familiar, which therefore falls quite outside the limits of the "canny", and is contrasted with it, filling the mind with blank wonder and astonishment.[68]

The *Mysterium* that is, the Wholly Other/God is known as the harmony of contrasts because of its dual structure. First, the *mysterium tremendum* which is an object that is awesome and daunting and which yields negative emotions. Secondly, the *mysterium fascinans* which is an attractive and fascinating object which generates positive emotions.

The *mysterium tremendum* refers to a negative emotion of tremor and fear, and is composed of the three elements of awfulness, majesty and energy/urgency. The *awfulness* element is oriented towards the feeling of a creature which trembles before the awe-inspiring object which it experiences. This leads to the element of *majesty*, whereby the individual becomes able to overcome the feeling of helplessness. The feeling of empowerment of the *mysterium tremendum* "may at times come sweeping like a gentle tide, pervading the mind with a tranquil mood of deepest worship."[69] This is followed by the element of *energy* which energises and activates the individual's will to meet the demands of the crisis situation. The *mysterium tremendum* may direct the individual towards or away from the *mysterium*, the Wholly Other/God.

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[66] William James, *The Varieties of Religious Experiences: A Study in Human Nature* (New York: Modern Library, 1929).

[67] Otto, *The Idea of the Holy,* xvii.

[68] Ibid., 26.

[69] Ibid., 12.

In contrast, the *mysterium fascinans* incorporates the element of fascination and wonderfulness, characterised by "love, mercy, pity, comfort... religious bliss or felicity."[70] This is exhibited by St Paul's exclamation: "What no eye has seen and no ear has heard, what the mind of man cannot visualise; all that God has prepared for those who love him."[71]Additionally, following the miraculous catch of fish, Peter fell on his knees before Jesus, saying: "Leave me, Lord; I am a sinful man."[72] These opposing dual characteristics of the *mysterium* form a "strange harmony of contrasts ... which is at once the strangest and most noteworthy phenomenon in the whole history of religion."[73] Thus, the *numinous* experience may trigger self-transcendence with resultant empowerment to confront harmoniously the current crisis situation.

The Theoretical Model of Causal Pathway for Mental Health Based on Western Monotheistic Religions

Since the participants in this study were all Roman Catholics, the focus of this model is oriented towards Christianity. However, "this model may also apply, with some modifications, to other monotheistic religious traditions"[74] that is, Islam and Judaism.

The development of religious practices, commitments, experiences and coping behaviours originate from the religious beliefs, relationship with and attachment to God. Christianity considers God as "separate from humans and creation, yet as personal and imminent."[75] This may be affected by present experiences and past influences from the family, religious and secular peer groups, and religious education from formal institutions.

This complex phenomenon includes the source (God), religious influences, and religious practices which are expressions of the virtues of faith, hope and love of God. This is called Religion, which is frequently used synonymously as Spirituality. Hence, this theoretical model which is oriented towards Christianity, considers Religion and Spirituality as similar concepts. However, it is argued that different populations may differentiate Religion from Spirituality. This is because Spirituality is a subjective concept which may be interpreted differently by individuals of different cultures, race, personal beliefs and religions.

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[70] Ibid., 31.
[71] 1Cor. 2:9 (NJB).
[72] Lk 5:8 (NJB).
[73] Otto, *The Idea of the Holy,* 31.
[74] Koenig, Carson and Kind, *Handbook of Religion and Health,* 308.
[75] Ibid.

Religion/Spirituality (R/S) may influence life decisions, the development of human virtues, present and past life experiences, education and personality traits. Similarly, R/S in turn, is also influenced genetically and this may enhance or inhibit its development. Religious beliefs are vital for cognitive appraisal of life events. For example, life circumstances happen with a positive reason whereby the believer may view the potential benefit out of both the positive and negative life events: "We are all aware that God works with those who love Him, those who have been called in accordance with His purpose, and turns everything to their good."[76]

Similarly, the belief in a protective God, who is conscious of the uniqueness of each individual - "I shall not forget you. Look, I have engraved you on the palms of my hands"[77] - may foster positive interpretation of life events which are eventually perceived as less threatening and less stressful.[78]

Depending upon the appraisal of stressors, healthy or unhealthy coping strategies may be adopted. Healthy coping may be emotion-focused, such as prayer or the seeking of assistance from clergy and/or the faith community, and/or problem-focused by seeking medical advice or by giving up smoking. Healthy religious coping contrasts with maladaptive coping strategies, such as denial, or drug/alcohol intake in an attempt to suppress the stressors.

R/S may also influence the utilisation of coping strategies are available at the time of stressful life events, such as the meaning and purpose of suffering in life, the presence or absence of family support, and the contribution of life stressors towards spiritual maturity. Religion may also influence ethical and moral decision-making which may also be further influenced by peer groups, life experiences and life events. The adoption of pro-social behaviours such as forgiveness, altruism, honesty, faithfulness and dependability may foster healthy relationships. Similarly, ethical and moral actions may generate the development of human virtues of faith, hope and love.

Finally, the health outcomes of the essence of religion, that is attachment to God, may be either positive or negative. For example, a relationship with God which is full of conflict and disharmony will more likely yield ill effects on holistic health. In contrast, spiritual growth may result from overcoming religious struggles such as during the process of coming to terms with personal suffering.

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[76] Rom. 8:28 (NJB).

[77] Isa. 49:15-16 (NJB).

[78] David Stevens and Lewis Gregg, *Jesus M.D.: A Doctor Examines the Great Physician* (Grand Rapids, Mich.: Zondervan, 2001).

Methodology

This descriptive exploratory research study (2000-2007) has analysed the perceived suffering of clients with heart attack across the first five years from the onset of their attack. The research was approved by the Chairperson of the Foundation for Medical Services (Malta) and the Medical Research Ethics Board of St Luke's Hospital, Malta. Clients' autonomy, privacy and confidentiality were maintained to safeguard their dignity. Every second Maltese speaking client who satisfied the selection criteria was recruited, namely those diagnosed with a first heart attack, possessing mental ability for retrospective data collection,[79] who were admitted to the Coronary Care Unit (CCU) and transferred to the medical ward in the local general hospital in Malta (Table 1). To increase retention of the sample across time, the clients were sent Christmas, Easter and birthday cards and the book "Spirituality in Illness and Care" published in 2003.[80]

The main question was *How do you relate the onset of and recovery from your heart attack with your religious beliefs/faith?* Since clients were all Roman Catholics, their response was focused towards a monotheistic orientation. The face-to-face interview was piloted across seven clients at the medical ward. Clients were eager to talk about their heart attack experience. Therefore, the pilot study indicated the need of reminding clients to talk about the religious perspective of their experience. The response rate between the first time (T1) and after five years (T7) interviews was 90%-53% (Table 2). Since the majority of clients had resumed work, the annual ten-to-fifteen minutes data collection interviews were carried out by telephone. To enhance privacy, the author's and participants' home telephones were used. The main data was collected by a double thirty-to-forty-five minute audio-taped face to face interviews on the clients' transfer to the medical ward (T1), and three months later (T2) at home. Data were collected in Maltese to enhance free expression of experiences. The quotations utilised for publication were translated jointly by a professional linguist and the author. Notes were taken by the author during telephone interviews, to which details were added at the end of each interview. Data collection was also a means of making clients recall their heart attack, so that counselling services from the hospital psychologist or chaplain could then be offered if deemed necessary.

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[79] Sutthichai Jitapunkul, Isweri Pillay and Shah Ebrahim, "The Abbreviated Mental Test: Its Use and Validity," *Age & Ageing* 20, no. 5 (1991): 332-336.

[80] Donia Baldacchino, *Spirituality in Illness and Care* (Malta: Preca Library, 2003).

Table 1: Demographic data of participants across the first five years after the heart attack

Time	N	Male	Female	Mean Age	SD
Recruitment from the CCU	*70	46	24	61.9 yrs	12.1
T1: On transfer to the medical ward (2000-2001)	63	40	23	61.5 yrs	12.3
T2: 13 weeks after discharge (2000-2001)	51	33	18	61.8 yrs	12.5
T3: 1st year after discharge (2001-2002)	35	20	15	62.5 yrs	12.1
T4: 2nd year after discharge (2002-2003)	30	16	14	62.9 yrs	11.8
T5: 3rd year after discharge (2003-2004)	25	13	12	63.4 yrs	11.3
T6: 4th year after discharge (2005-2006)	20	9	11	63.8 yrs	11.4
T7: 5th year after discharge (2006-2007)	16	7	9	64.2 yrs	11.7

**Religious Affiliation: All Roman Catholics*

Table 2: Response rate of participants with heart attack across time

Time	n	Male	Female	*Response rate %
Recruitment from the CCU	*70	46	24	-
T1: On transfer to medical ward (2000-2001)	63	40	23	90%
T2: 13 weeks after discharge (2000-2001)	51	33	18	81%
T3: 1st year after discharge (2001-2002)	35	20	15	78%
T4: 2nd year after discharge (2002-2003)	30	16	14	71%
T5: 3rd year after discharge (2003-2004)	25	13	12	64%
T6: 4th year after discharge (2005-2006)	20	9	11	57%
T7: 5th year after discharge (2006-2007)	16	7	9	53%

** Some clients were excluded due to the development of complications e.g. heart failure and impaired hearing and dementia, whilst few withdrew from the study*

Data was transcribed and analysed manually in line with the Content Thematic Analysis framework.[81] Following repeated reading of the data, open categorisation along the transcript was first performed, followed by the integrating of similar categories, which generated two main themes across time. This process was guided by the analysed research and the theoretical framework of this study composed of "The Idea of the Holy"[82] and the "Theoretical Model of Causal Pathways for Mental Health, Based on the Western Monotheistic Religions."[83] The face to face and telephone interview transcripts were validated by the majority of participants across time (70% - 85%) with a high rate of agreement. Inter-rater analysis of a random sampling of fifteen transcripts was performed by a colleague graduate in Religious Knowledge with an agreement of 95%, denoting confirmation of the themes. Reflection along the long pathway of the research process has contributed towards reducing bias and enhancing trustworthiness of data.

Findings and Discussion

This descriptive longitudinal exploratory study has identified the religious perspective of the mystery of suffering from first time acute heart attack, followed by the possible complication of chronic heart disease across the first five years following the onset of the illness. The qualitative data across time shed light on the religious perspective of the mystery of suffering in clients from Malta who were all Roman Catholics. For confidentiality purposes, quotations in text are here supported by the original code number (1-70); gender (M=male, F=female); age as recorded on recruitment and time (T1=On transfer to the medical ward; T2=13th week post discharge; T3: 1st year; T4: 2nd year; T5: 3rd year; T6: 4th year; T7: 5th year.

The qualitative data has generated two main themes from the first two face to face interviews, consisting of both the positive and negative perspectives of suffering. These themes were further explored across the five years by telephone. While comparing these findings with research, rationale was deduced from the Theoretical Framework of this study.[84]

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[81] Philip Burnard, "A Method of Analysing Interview Transcripts in Qualitative Research," *Nurse Education Today* 11, no. 6 (1991): 461-466.

[82] Otto, *The Idea of the Holy.*

[83] Koenig, McCullough and Larson, *Handbook of Religion and Health.*

[84] Otto, *The Idea of the Holy;* Koenig, Carson, King, *Handbook of Religion and Health.*

1. Security from a trustful relationship with God
2. Alignment with the will of God

On realising the personal significance of the diagnosis of heart attack, communication with God was a means of overcoming clients' loneliness and providing them with security. The clients' perception of a heart attack was oriented towards fear of impending death.

Security from a Trustful Relationship With God

Clients' communication with God through prayer yielded a sense of safety and a feeling of caring from God. However, the sudden onset of a heart attack triggered a self-evaluation of their whole life on realising the high risk of impending death. The following young male client acknowledged his lack of relationship with God and his failure of setting a good example to his children. Thus he felt guilty and confessed that he deserved such a severe illness as it served him a lesson, and he was determined to undertake a healthy lifestyle:

> I was very anxious when I had the heart attack, especially when I could not understand why God permitted this to me. I asked myself, "Why me at such a young age?" So many others are leading a worse life than me! Why me? Then I reflected and realised that this was a warning from God, because I felt I had been cruel towards God, because I had stopped going to church, I blasphemed even in the presence of my sons. All this crossed my mind; it pricked my conscience and I sincerely admit that "I deserve worse than this." I badly needed this warning to change my life. I was really afraid to face God. Additionally I was also a chain smoker but I need to sort out myself, I mean, get my priorities right. (T1: M35,44yrs)

In the acute phase, clients - especially those of a younger age - expressed their disappointment about the onset of their heart attack. The perceived severity of the heart attack triggered a feeling of self-pity and loneliness because clients felt that they had lost control over their life. However, when they prayed to God, clients felt better and secure, as they could acknowledge the love of God towards them. This demonstrates the *numinous* experience whereby clients' feelings of nothingness generated a yearning to reach towards a higher power.[85] Since all clients were Roman Catholics - although some were not practising their religion - they all turned to God to save their life and help them cope, with a determination to change their lifestyle both physically and spiritually, such as by giving up

[85] Otto, *The Idea of the Holy*.

smoking and resuming their religious practices. Thus, clients' attachment to God yielded a positive health outcome which influenced their holistic quality of life.[86]

In contrast, some clients who classified themselves as religious felt the absence of God's presence in the acute phase, as they were overwhelmed by the chest pain and by the fear of detaching themselves from their dear family.

> I felt that I was being abandoned by God. However, I tried to believe that He would help me. I'm a devotee of the Sacred Heart of Jesus. The thought of death scared me. I feared that I would die without seeing my two daughters, one of whom is married, and not seeing again my sons, the treasure of my husband. At that time, this fear left me helpless and I didn't have the strength to pray. However, now after two years I have become closer to God and to my family. I thank God continuously for having saved my life. (T4: F25,55yrs)

During the most severe chest pain, some clients concentrated more on the potential loss of their beloved family, and this inhibited them from the formal way of praying which is an emotion-focused religious coping.[87] However, in time, clients were found to have turned to God in a trustful relationship. This is consistent with research studies which show that religiosity through prayer in disability and chronic illness is a primary resource of coping. This is because clients relate with God as their paternal father who is deemed as a resource of strength and comfort. [88] Daily personal and communal prayers of thanksgiving to God and the Saints most commonly identified when clients appreciated more the preciousness of their life day by day. The use of religious icons was a means of empowerment which helped them overcome their fears and loneliness. Thus, religious coping may demonstrate clients' expressions of faith, hope, and love of God.[89] This reflects current research whereby religious items may provide comfort, courage, and a means of coping with illness.[90]

By the third year of their recovery, some older clients were found to develop symptoms of chronic heart disease, such as shortness of breath and other problems like limited mobility, and living alone after the death of their spouse. However, these clients remained consistent with their relationship with God

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[86] Koenig, Carson and King, *Handbook of Religion and Health.*

[87] Ibid.

[88] Aru Narayanasamy, "Spiritual Coping Mechanisms in Chronic Illness: A Qualitative Study," *Journal of Clinical Nursing* 13, no. 1 (2004): 116-117; Baldacchino, *Spirituality in Illness and Care.*

[89] Koenig, Carson and King, *Handbook of Religion and Health.*

[90] Miller, McConnell and Klinger, "Religiosity and Spirituality," 299-311; Kaye and Raghavan, "Spirituality in Disability and Illness," 231-241.

through prayers and rituals. In contrast, some clients returned to their normal life routine and became over-occupied with their daily work schedule and family commitments. Hence, it appeared that the return to their hectic life made them feel self-reliant in such a way that they seemed to forget the severity of their acute illness. Their communication with God became more of a personal relationship through personal prayer rather than through communal prayers and church attendance. Hence, attachment to God is a personal and unique relationship for each individual, which could also be different from time to time due to various influences in life.[91]

> Now that my heart attack is over, I think that my heart has settled down after four years! At first I felt distressed when I felt guilty for not keeping with my diabetic diet. So I felt I was to blame for this attack. But it's no use of crying now. I still pray God to keep me healthy so that I will continue to take care of my son who has with special needs. Hopefully, things will continue to get better day by day. (T6: M08,57yrs)

During the acute phase, the majority of clients managed to change their lifestyle, both physically - such as through a healthy diet and compliance with treatment - and also spiritually, declaring that the illness itself had brought them to their senses and made them realise the importance of God in their life. This may be because of their willingness to live, and their belief in God as a healer;[92] and also in viewing their future with a positive outlook.[93] Thus, life experiences and the utilisation of coping strategies available at the time of stressful life events, may enhance clients' spiritual maturity.[94]

The first anniversary of their heart attack was again a reminder to clients of their severe illness its possible complications, such as the danger of another heart attack or chronic heart disease. A few clients developed some complications during the first two years after the heart attack and were treated by an angioplasty. This urged them to remain compliant and trustful in God's help,

> I really felt down when I underwent an angioplasty after two years of my heart attack. I'm afraid that it might happen again. That feeling of uncertainty frightens me and upsets me because I'm afraid that I will have another attack and die of it.

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[91] Koenig, Carson and King, *Handbook of Religion and Health.*

[92] Harvey, "Self-Management of a Chronic IIlness," 75-88; Barbara Montgomery Dossey, Lynn Keegan and Cathie E. Guzetta, *Holistic Nursing: A Handbook for Practice,* 3rd ed. (Gaithersburg, Md.: Aspen, 2000).

[93] Hutton and Perkins, "Man's Experience of Myocardial Infarction," 87-97; Philip J. Barker and Poppy Buchanan-Barker, *Spirituality and Mental Health* (London: Whurr, 2004).

[94] Koenig, Carson and King, *Handbook of Religion and Health.*

> So I turn to the Sacred Heart of Jesus and have faith in God's help. It's a blessing that my family supports me throughout. (T4: F54, 61yrs)

Life uncertainties appeared to increase clients' prompt alertness towards any signs of deterioration. This fear leads individuals to live with intense physical and psychological stress.[95] As time went by, clients' relationships with God remained stable across the first three years but were found to decline during the fourth and fifth years after the heart attack. The feeling of self-sufficiency appeared to make them feel independent. Social support, especially from family and friends is a means of coping and may contribute to a meaningful life.[96] Thus, clients' relationships with God appeared to be a resource of strength during periods of frailty.[97] Clients' relationship with God originated since childhood and that same God was always at the back of their mind. Hence, attachment to God may be influenced by past life experiences.[98] Clients knew that it was a means of security and of coping with the onset of heart attack and adapting to the complications arising across time. These findings are consistent with research studies which show that social support and spiritual beliefs are important coping strategies.[99] Faith and prayer provided clients with comfort, strength and other positive outcomes such as fulfilling their roles in life.[100] Additionally, clients' faith in God empowered them to assume control over their health and become responsible of their compliance with cardiac rehabilitation.[101] This runs parallel with research studies which confirm the positive effect of the religious dimension on health. Prayer was identified as an effective coping strategy whereby individuals become

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[95] Rowe and Allen, "Spirituality as a Means of Coping," 62-66.

[96] John L. Cox, Alastair V. Campbell and Kenneth W.M. Fulford, *Medicine of the Person: Faith, Science and Values in Health Care Provision* (London: Jessica Kingsley, 2009); Dawn Peerbhoy, "Approaches to Healthcare: Connectedness and Spirituality," *Journal of Holistic Healthcare* 6, no. 1 (2009): 332-337; Viktor E. Frankl, *The Doctor and the Soul: From Psychotherapy to Logotherapy,* 3rd ed. (New York: Vintage Books, 1986); Wendy Greenstreet, "From Spirituality to Coping Strategy: Making Sense of Chronic Illness," *British Journal of Nursing* 15, no. 17 (2006): 938-942.

[97] Otto, *The Idea of the Holy.*

[98] Koenig, Carson and King, *Handbook of Religion and Health.*

[99] Maxine A. Adegbola, "Spirituality and Quality of Life in Chronic Illness," *The Journal of Theory Construction and Testing* 10, no. 2 (2006): 42-46; Selman et al. "Psychological Distress in Heart Failure Patients," 260-266.

[100] Harvey, "Self-Management of a Chronic Illness," 75-88; Aru Narayanasamy, "Spiritual Care of Chronically Ill Patients," *British Journal of Nursing* 5, no. 7 (1996): 411-416.

[101] Heidemarie Kremer, Gail Ironson and Martina Porr, "Spiritual and Mind-Body Beliefs as Barriers and Motivators to HIV-Treatment Decision-Making and Medication Adherence?: A Qualitative Study," *AIDS Patient Care and STDs* 23, no. 2 (2009): 127-134.

empowered to accept their situation and align themselves peacefully with the will of God.[102]

Alignment with the Will of God

At the onset of a heart attack some clients felt critically ill, and acknowledged the fact that they were on the point of death. While praying to God to relieve their insurmountable chest pain, clients thought of their beloved family and their unfinished business in life. However, they turned to God for help as they wished to align themselves to the will of God through the intercession of the Holy Mother,

> I was afraid of death as I thought I was going to die and that I was going to leave my dear wife behind me. She respected me and our children so much that it was difficult at the time to detach myself from my family... I prayed in silence and felt I should entrust myself into God's hands. "Sacred Heart of Jesus, I trust myself in you. Oh Virgin Mary, please intercede for me." Now that I have survived my heart attack, I can understand what it means to try to resign oneself to the will of God and leave one's family behind. I thank God for saving my life. (T3: M17, 74yrs)

During the immediate acute phase of the heart attack, clients could realise that they had lost control over their life, and were forced to detach themselves from their family. Hence, they turned to God through prayers for security and empowerment.[103] This is consistent with research studies which show that clients may turn to their God/Ultimate Other for help in times of distress, in an attempt to align themselves with the will of God.[104] Such research provides evidence about the efficacy of spirituality and prayer during stressful situations, which may lead to a positive outcome in health.[105]

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[102] Baldacchino, *Spirituality in Illness and Care;* Larry Dossey, *Prayer is Good Medicine* (San Francisco, Calif.: Harper Collins, 1996); Margaret A. Burkhardt, "Becoming and Connecting: Elements of Spirituality for Women," *Holistic Nursing Practice* 8, no. 4 (1994): 12-21.

[103] Otto, *The Idea of the Holy.*

[104] Koenig, Carson and King, *Handbook of Religion and Health;* Delgado, "Sense of Coherence," 229-234; Baldacchino, *Spirituality in Illness and Care.*

[105] Patrick R. Steffen et al., "Religious Coping, Ethnicity and Ambulatory Blood Pressure," *Psychosomatic Medicine* 63, no. 4 (2001): 525-530; Harold G. Koenig, *The Healing Power of Faith: How Belief and Prayer can Help you Triumph over Disease* (New York: Touchstone, 2001); Margo A. Halm, R. M. Myers and P. Bennetts, "Providing Spiritual Care to Cardiac Patients: Assessment and Implications for Practice," *Critical Care Nurse* 20, no. 4 (2000): 54-72.

Prayer fosters positive beliefs that create a sense of meaning and purpose, particularly when clients are faced with a life-threatening illness.[106]

> First I need to free myself from my guilt feelings as I can't rewind my life back! I will manage through God's help! I'm still very weak but am determined to look after my health... Let God's will be done upon me! It's not a joke to stay still and resign oneself to the will of God, as I would like to live longer and compensate for my mistakes in life. Now that I have come face to face with death, I thank God that I'm still alive, because in such a critical situation one becomes very aware of one's life, one's actions and mistakes. I am determined to prioritise my life values. My first priority is my health and my family. (T2: M22, 58yrs)

Alignment to the will of God drives individuals to modify their personal life goals while prioritising life values. These individuals were determined to lead a healthy life style in order to fulfil their purpose in life and also to atone for their mistakes. This is consistent with research studies which show that religiosity also changes the person in response to life-altering events.[107] The majority of clients referred to their giving priorities to a healthy life style, quality time with their family, and religious practices, such as forgiving others and seeking forgiveness through the Sacrament of Reconciliation.

> Apart from wanting to go to confession, as I knew that something serious had happened to me, I felt distressed when I thought about my brother and sister who were not on good terms with me. When I was young, since I was the eldest, I had emigrated to Canada to support my family financially. Now that I have gone on early retirement and have returned to Malta to enjoy a good quality life, this heart attack took me by surprise. It was a great blow to me... Let God's will be done! They didn't appreciate my sacrifice at all *(crying).* However my sister came to visit me in hospital. Mind you I talked to her because I hate quarrelling. I will suffer all this for my children and grandchildren to remain united with my family. (T2: M42, 55 yrs)

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[106] Hutton and Perkins, "Men's Experience of Myocardial Infarction," 87-97; John F. Rossiter-Thornton, "Prayer in Your Practice," *Complementary Therapies in Nursing & Midwifery* 8, no. 1 (2002): 21-28.

[107] Donia Baldacchino, D. Agius and D. Cachia, "The Spiritual Dimension in Adaptation in Chronic Illness: A Comparative Study," in Baldacchino, Narayanasamy and Mead, eds., *Spiritual Care: Being in Doing* (Malta: Preca Library, 2010), 103-122; Donia Baldacchino et al., "The Spiritual Dimension in Adaptation in Chronic Illness: A Comparative Study," in Baldacchino, Narayanasamy and Mead, eds., *Spiritual Care: Being in Doing,* 295-316; Vance, Struzick and Russel, "Spiritual Implications of Aging with HIV," 21-38.

This client showed the need of forgiving his brother and sister but also the need to renew his relationship with God through the sacrament of reconciliation. This shows the importance of pastoral care in the management of clients with acute illness. Turning to God is a means of communicating and achieving harmony with God.[108] The client identified a purpose to his suffering, that is the unity of his family; and such purpose may eventually be therapeutic to clients, generating greater meaning and peace in life.[109] However, the life threatening illness appeared to trigger in the client a need to settle his life peacefully, while aligning himself to the will of God. Renewal of relationship with God and family could have been triggered by his belief in an after-life, which appears to have led the client to forgive and be forgiven, in preparation for his unity with God, his Heavenly Father.[110] Forgiveness is well documented to be significantly related to a good mental health and spiritual well being.[111] This may be so because pro-social behaviour may strengthens social relationships which may then generate positive appraisal of stress and well-being.[112]

In contrast, when clients have an impaired relationship with God, they might find it difficult to align themselves with the will of God until they come to terms with their failure and sort out their relationship with God,

> This heart attack challenged my stubborn character. My doctor had advised me several times against smoking. I remember being angry with God for such a dangerous illness. I had thought that I was leading a good life as opposed to others who were not behaving well.....Now that I'm better, and without pain, I seek God's forgiveness for these negative thoughts about Him. Also, I can look forward optimistically. I have managed to keep my promise to stop smoking for good, and I'm enjoying my health. Of course, it's a continuous struggle to cooperate with medical advice....Otherwise I would be tempting God and will suffer the consequences of ill health. (T7: M56, 61yrs)

This patient has expressed his failure of living up to his expectations and of expressing his anger towards God for having permitted such a severe illness

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[108] Lodovico Balducci and Russell Meyer, "Spirituality and Medicine," *Cancer Control* 8, no. 4 (2001): 368-375.

[109] Bekelman et al., "Spiritual Well-Being and Depression in Patients," 470-477; Narayanasamy, "Spiritual Coping Mechanisms," 116-117.

[110] The Catholic Church, *Catholic Church Catechism*.

[111] Ruth A. Tanyi, "Towards Clarification of the Meaning of Spirituality," *Journal of Advanced Nursing* 39, no. 5 (2002): 500-509; Michael R. Levenson, Carolyn M. Aldwin and Loriena A. Yancura, "Positive Emotional Change; Mediating Effects of Forgiveness and Spirituality," *Explore* 2, no. 6 (2006): 498-508.

[112] Koenig, Carson and King, *Handbook of Religion and Health.*

on him. Concurrently, the client demonstrated his spiritual distress and the need to reflect on his life, the need of auto-forgiveness and to be forgiven by God, and the need to show his gratitude towards God by modifying his life. A negative relationship with God may generate conflicts and disharmony which can threaten the meaning of life. In contrast, working through religious struggles may contribute towards an alignment with the will of God, which is based on a trustful relationship.[113]

> At first, during my chest pain, I forgot the love of God towards me. I always believed that God would not permit anything on me, beyond my coping abilities ... However I turned to God and questioned Him "what's next?" I suffered a lot in my life ... But as time went by, I trusted in God and then I felt in line with God's will. (T3: F51, 73 yrs)

Although questioning God for the heart attack, the existing trustful relationship with God appears to overcome self-pity, and foster alignment with the will of God, even in times of distress. While reflecting on their acute phase, clients were found - consistently across the five years - to sort out and maintain their relationships with God.

Irrespective of age, gender, education and other demographic characteristics of the participants, in the acute phase clients were found to turn to God and accept their illness gradually across their recovery, through the help of pastoral care and social support. Therefore, the onset of a life threatening illness appears to foster communion with God, enhance coping, and create a harmonious alignment with the will of God,[114] while stimulating clients to do their best in their commitment to comply with their rehabilitation.

The findings indicate that from the third year onwards, clients tend to lessen their motivation to pray as opposed to the acute phase, which appears to trigger clients to turn to God for help.[115] This may be because clients with chronic illness become accustomed to the symptoms of their illness, and tend to adapt themselves to their chronic condition.[116] These findings are consistent with existing research which shows that clients with a weak relationship with God are liable to experience disturbance in their belief system on the onset of a life threatening illness.[117]

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[113] Ibid.

[114] Baldacchino, *Spirituality in Illness and Care;* Koenig, Carson and King, *Handbook of Religion and Health*.

[115] Ibid.

[116] Anna Rita Giovagnoli, Rute F. Meneses and Antonio Martins Da Silva, "The Contribution of Spirituality to Quality of Life in Focal Epilepsy," *Epilepsy & Behaviour* 9, no. 1 (2006): 133-139.

[117] Baldacchino, *Spirituality in Illness and Care;* Koenig, Carson and King, *Handbook of*

Research suggests that when individuals consider illness as a punishment from God or feel abandoned by God, they tend to have higher risks of experiencing negative emotions, such as anxiety and depression.[118] This may be due to the lack of alignment with the will of God, or to a perception of no reciprocal response from God as their prayers appear unanswered.[119] However, on recognising their nothingness in the acute phase, clients were found to self-transcend to God with an intention to change to a healthy lifestyle.[120] They can thus, cope with the severity of their acute illness with less negative emotions[121] and leading a meaningful life.[122]

Limitations

Qualitative data was collected seven times during the acute phase, followed up by annual telephone interviews across the first five years. In-depth data from the first two interviews generated two main themes which were further explored through the five years of the clients' recovery from their first heart attack. Here the telephone responses were briefer and without the observation of non-verbal cues. Replication of this study is therefore being suggested on clients with various types of acute and chronic illness, in order to compare and explore further, by means of in-depth data, clients' holistic experiences of suffering and the influencing variables. This descriptive longitudinal exploratory study has managed to identify fluctuation of results across time. Further cross-cultural research with a mixed-method approach is therefore being suggested in order to help identify possible differences in the perceived suffering between subgroups of bio-psycho-social-spiritual demographic characteristics.

Conclusion

Prior to this study, research on heart attack had been mainly conducted across the first three to twelve months from the onset of heart attack. This descriptive exploratory study has provided new knowledge on the religious perspective of

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Religion and Health: Koenig, *The Healing Power of Faith.*

[118] Kenneth I. Pargament et al., "Religious Struggle as a Predictor of Mortality Among Medically Ill Elderly Patients: A 2-Year Longitudinal Study," *Archives of Internal Medicine* 161, no. 15 (2001): 1881-1885; Koenig, Carson and King, *Handbook of Religion and Health.*

[119] Otto, *The Idea of the Holy*.

[120] Koenig, Carson and King, *Handbook of Religion and Health;* Baldacchino, "Anxiety, Depression and Spiritual Well-Being."

[121] Koenig, Carson and King, *Handbook of Religion and Health.*

[122] Blinderman et al., "Symptom Distress and Quality of Life," 594-603; Miller, McConnell and Klinger, "Religiosity and Spirituality," 299-311; Griffin et al., "Spirituality and Well Being among Elders," 669-765.

suffering as perceived by clients during the first five years following their heart attack. The qualitative research process supported by the theoretical framework has generated in-depth data and has provided a rationale to the clients' perceived experiences across time.

The religious experience of suffering has been explained under two themes namely, "Security from a trustful relationship with God" and "Alignment with the will of God." Findings have demonstrated both the positive and the negative dimensions of the religious perspective of suffering, which were found to be consistent with existing research surveys. In the acute phase individuals were found to turn to God for empowerment as a means of recovering their health, and that they attempted to give meaning to their suffering through gradual alignment with the will of God. In contrast to the limited existing research studies, alignment in this study has been associated with the clients' cooperation with the will of God as opposed to their surrendering themselves passively to God.

Irrespective of demographic characteristics, the perceived life-threatening illness of a heart attack in the acute phase was pivotal in triggering individuals towards religious coping. On the other hand, gradually, as individuals' state of health became stable, a decline in religious coping strategies was identified, accompanied by a non-compliance with medical treatment. Thus, the *numinous* experience during the acute phase of illness appeared to motivate the individuals to self-transcend to God for empowerment. Similarly, the clients' personal relationship and attachment to God seem to have been the sources of initiation and guidance towards religious practices and commitments.

In times of frailty, clients were found to turn to God, the Mystery, in an attempt to understand the mystery of suffering and become empowered to cope with their illness. This underlines the need for care by qualified pastoral personnel, and a multidisciplinary team equipped with competence in spiritual care. Consequently, spirituality needs to be integrated within the undergraduate and post-graduate training programmes of student nurses and the multidisciplinary teams in order to help address clients' suffering holistically.

Donia Baldacchino
Dept of Nursing
Faculty of Health Sciences
University of Malta
Msida MSD 2080
Malta

donia.baldacchino@um.edu.mt

Aaron Tonna
Medical Ward
Mater Dei Hospital
Msida
Malta

aaron.tonna@gov.mt