
How Narrative Is Used for Grieving and Healing: A Thematic Case Story from Pastoral Care in Cardiology

by Rev. Robert J. Yim

Biomedical technology allows us to map the genetic landscape of the human cell. Yet such an inside look into molecular structure does not reveal what animates and replenishes human life. The vitality and value of human life are contextualized in each person's hopes and meanings, experiences and struggles. A glimpse into what makes a person most alive is provided neither by science nor by technology, but through the particular narratives that bespeak each individual's unique journey and worth. Not frivolous fiction, metaphors communicate viable sense for events too significant to disregard.

"I just want one more day of life," says Tim, a 49-year-old man who was hospitalized with 40 percent heart function for evaluation of a possible heart transplant. His recent business success overshadowed the pain of growing up in an alcoholic family and the failure of his first marriage. Tim had married again, and his hopes for a promising future with a new family were reflected in his golf swing. Yearning always for a sunny day on the greens, Tim's hospital stay extended from September past his 50th birthday on Christmas Eve. On his 50th birthday, had Tim lived half his life, or was his life speedily coming to an end?

A patient enters an acute care hospital to procure a diagnosis and treatment for a physical disease. But there can abide with the person certain pre-existing personal losses and stagnant grief, which generate a *spiritual dis-ease*. Alongside the physical malady, the patient brings to the hospital a subtle affliction of unresolved grief caused by and contextualized in gripping personal events. His or her ability to adjust and move beyond these incidents may be blocked by loss and deprivation.

Such losses can be the death of a dear one months before the physical symptoms present themselves. Another upset may be a drastic decline in health which focuses anxiety around fate and mortality. Unsettling job changes can dislodge familiar routines and cause stress. These dislocations take on unexpected significance and constitute the stressors that absorb the patient's emotional energy and preoccupy his thoughts. The patient's

Father Robert J. Yim, M.Div., M.A., is specialist chaplain for cardiology at Barnes Hospital at Washington University Medical Center in St. Louis, Missouri.

more immediate physical pain may be felt in the body and limbs. But life's compelling circumstances can traumatize the human spirit and create stress in an individual's life. The hospital stay becomes a metaphor for the patient's inner ordeal.

The acute care setting is equipped to take a patient from home into an environment of innovative technologies and special protocols. These interventions thoroughly examine the body and suggest treatment. The multi-disciplinary medical team can ask the patient specific clinical questions with expertise and experience. However, the patient's deeper concerns, which assault the human spirit's vitality and capacity for effective recovery, are often left lingering and unattended. Healing and restoration of the whole person require skilled clinical assessment not provided by medicine, that taps into the solitude of stress and gently knocks on the door of privacy. Pastoral care professionals provide patients, their families and staff the cutting-edge expertise of hospital chaplains who work as members of the healing team. Pastoral care studies the relationship between a person's spirituality and disease process. Pastoral caregivers investigate how a particular disease impinges upon a person's spirituality, and how, through skilled pastoral intervention, a person's spirituality can affect the disease process.

Through a specific clinical tool—spiritual assessment—pastoral care can identify the undercurrent concerns of acute care patients, hence greater recovery is accomplished. The spiritual assessment tool is specifically developed to match the psychodynamic patterns of a particular disease process. By understanding human behavior in response to disease, pastoral care can effectively address a patient's cop-

ing struggles during hospitalization and afterwards at home. Healing begins because an interested human partner is invited to share empathetically in telling the ultimate stories of ambiguity and paradox.

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The case story presented in this article will demonstrate how spiritual assessment and narrative are jointly used with cardiac patients, to maximize their recovery from surgery and transplantation. Narrative helps move the patient through the shock of grief, so he or she can gradually face the foreboding events still ahead: surgery, intubation, intensive care and physical rehabilitation. Pastoral care for cardiology believes that narrative can especially assist the patient in the pre-surgical therapeutic movement from denial toward a moral act of judgment. Such a judgment, which sees the probable outcomes of surgical and medical interventions in one's favor, empowers the patient past victimhood. The patient eventually takes charge of the recovery process.

After some time, Tim was listed "priority one" on the heart transplant list. When pastoral care made the first clinical visit, it seemed that both Tim and his wife, Jacquelyn, were talking their feelings. Later it became evident that Tim's apparent optimism was actually disguised denial. "I just want a new heart!" mirrored his deepest wish to have a hassle-free life. So much shame and unarticulated anger lay dormant in his old heart. Yet Tim had to face the probing spiritual question: Who was the master and who was the slave? Was he truly the master of his feelings, able to keep them from surfacing and showing their raw intensity? Or was he the slave of emotions that dominated his moods and lodged within his heart his deepest fears, regrets and never-shared stories of suffering?

Like all pre-transplant candidates in his condition, Tim asked aloud: "Am I going to die before a heart becomes available?" Tim could not face the clear possibility that he might die, so he made himself believe that he was really not "that sick." Tim simply moved his work office into his hospital room, conducting business as usual with clients over the phone! In the hospital he ran up his American Express statement, by skipping the prescribed low-fat diet for more tasty fare, delivered to his room from his favorite local restaurants.

There was a "breach" between what Tim wanted to believe about himself and how he actually lived. This "divided" self considered strength to be a

mental skill that could control his fate and stall death. Tim's inability to grieve the permanent loss of his heart function was rooted in being unable to connect with his feelings.

Narrative can be used as a first step into the bewildering shock of grief. Many patients are paralyzed in grief because the pain seems intolerable as the grieving touches memories and emotions too powerful to reenact and face again. Denial becomes a legitimate and necessary strategy for coping temporarily with trauma, by deliberately holding oneself away from the source of chaos and confusion, usually by intellectualizing the situation. But a harmful consequence of such rationalization is that grief is interminably suspended because the patient is unable to enter into feelings. To anesthetize these feelings is to eradicate the patient as a major player in an event, which holds tremendous personal meaning. Consequently, the patient doesn't take initiative in his or her own life. Contrary to the proverb, time does not always heal; time often dulls the hurt. Despite the hurt or numbness, grief resides in the patient's story as an untapped resource for healing. For the pain encountered in grieving is the very energy that heals. Narrative helps the patient find his or her place in intimate stories of loss and grief. When the story can finally be shared, healing takes place as the patient is released from the bondage of his or her feelings.

As Tim was narrating the heart attack that led to his hospitalization, he experienced difficulty breathing. He was desperately trying to get the next bit of air. The word "bit" described hanging on to a shadow element next to nothingness or oblivion. Yet whatever that little "bit" would be for Tim, it would keep him hopefully alive for the next breath. An important pastoral care issue was to identify what that "bit" represented spiritually for Tim as it would determine his kernel reason for hoping. If "bit" could be used as a metaphor to describe his identity and spiritual relationship with an Ultimate, then even the smallest grain of "God" would keep him alive and hopeful as a spiritual person.

Tim was more used to "reaching out" than "reaching in." His former joviality faded to the point that he asked people to visit him less often. In January, just after his birthday, Tim's condition worsened. It was increasingly more wearisome for Tim mentally to control his anxiety. The bottom was falling out of his mind-made world. His cardiologist referred him to pastoral care for a clinical spiritual assessment.

Tim anticipated my arrival. He had a speech rehearsed in his head; he was ready to recite from the Alcoholics Anonymous book of daily affirmations as proof that he had not lost his grip on what was happening to him. Tim expected the chaplain to de-

liver consolation, and he was prepared to tell me that he did not need to be rescued or "saved." He was politely controlling his dignity, a sentry to the fortress of dark secrets and undisclosed sentiments. In standing guard over his heart, Tim did not realize that his heart was a prisoner!

The difference an adept clinical specialist chaplain makes in providing pastoral care is that he or she can skillfully press discomfort in order to separate the person from the grip of denial. I caught Tim off-guard by directly confronting his denial. He expected me to cooperate unwittingly with his scheme of self-sufficiency. But by studying his narratives made on previous visits, I was able to notice and hear an inner agony. That inner agony cried out for "a voice" to utter and explore the meaning of his pain. I was not to be that voice, but a supportive partner as he learned to say aloud what mattered most to him in living. Tim needed to find his own voice for the realm of his inner life so that he could hear himself articulate the meaning of his life story. I invited Tim to step into the feelings that encircled his story like a cocoon that houses an emerging butterfly.

Narration differs from reporting. Reporting captures the objective viewpoint and rationalized rendition of a scenario, whereby the teller stands outside the situation and stares into the event. In narration, by contrast, the teller stands inside the experience and releases the feelings bravely endured there. Reporting, as a method, talks about what happened to a person; narrative, as an intervention strategy, tells how one actively experienced what happened. During the spiritual assessment clinical interview, the chaplain seeks to identify the particular stressors that significantly affect a patient's life. The chaplain invites the patient to say aloud what happened, and directs him or her more and more into the layers of feelings. The underlying trust and confidence between the two partners in the narrative relationship create the ambience whereby the patient's inner truths can be clearly seen and spoken. This trust is not achieved instantaneously or automatically.

Tim did not want to take me up on my invitation. Instead of finding "voice" for his interior world, he resorted to the habitual clamor of complaint and blame. Although he initially rejected my challenge to his denial, later on he admitted to himself that he could not forget my questions. He was pondering the implications of my words and feared most of all that I might be right. Could he benefit from what I suggested? Two weeks later, in the early hours of a Saturday morning, he awoke from a nightmare and wanted to throw a chair through the windows of his room. Distressed, Tim asked for me. Tim was

now totally "inside" his feelings and was ready to narrate and share his story.

Narrative helps the patient find his or her place in stories of grief and loss.

Are all the stories that people tell about themselves ethically sound? Do they disclose an indisputable, inner truth? Not always, but it can be argued that if a story is worth saying aloud, then it holds some purpose or intent. A story can entertain, inspire, investigate, reveal or even wrap itself in a shroud of silence. A person can say something by not saying anything at all. Stories presume a partner, a listener. Even if one should say aloud one's story to a companion pet, there is a purpose to the telling. Stories are meant to bespeak an identity, and that identity seeks meaning and community. Identity is the seedbed for hope, and in hope the person aspires to a "truth" for the self. A story is like a cell in the body which contains all the DNA for the whole body. Through a single story the careful listener hears how the narrator approaches all of life.

Tim was amazed at my joy that he was finally making progress. He had expected a lecture about destructiveness and violence. This pivotal episode initiated further conversations, first about what he did not believe and then what he wanted to believe. His talk was no longer idle chatter or entertaining humor. Tim was establishing an intimate identity of disclosure, and by telling his story he could construct hope.

Tim shared stories about his childhood. He vividly remembered an incident when his best friend callously insulted him by referring to his "old man as nothing but a drunk." The memory stirred to life again because this childhood friend had died a year ago, and his son came to visit Tim. As Tim was living more within his feelings and grew more comfortable there, the unblocked grief led to greater healing of memories and former relationships. Tim began contacting childhood friends over the phone and renewing bonds with them. He began to tell people what he was feeling and that he liked them. His marriage with Jacquelyn improved and became less stressful, and his siblings and grown children heard sentiments never before uttered. The older language of individualism was reaching into unexplored territory: the language of moral sensibilities.

Narratives communicate two different kinds of language. A listener of narratives needs to appreciate this distinction in interpreting what the other partner is actually saying. As Robert Bellah aptly in-

dicates in his book *Habits of the Heart*, the first type of language speaks more about rights and individualism—how one is to be recognized, treated and esteemed as autonomous and unique. However, the second type of language deals with moral sensibilities, or why a person invests in and holds on to these rights over a lifetime. A person caught in an ethical dilemma will make a decision not merely by considering the personal values involved, but because of the quality which he assigns to these values. The threat of imminent death forced Tim to contemplate the basic question of existence: "What is the value of my life?"

Over the next month, Tim's condition actually improved, to the point that the cardiac team seriously considered bypass surgery as an alternative to transplantation. The dilemma Tim now faced was over which intervention would give him the greater number of years. The cardiac picture was further complicated by a large aneurysm of undetermined size on the heart. If Tim opted for a heart transplant, then he would have the emotional uncertainty regarding when a heart would be available, if ever. If he chose bypass surgery, he could have an immediate intervention that would save his life, but he was frightened about the danger of the aneurysm. Certainly the threat of death was real in either option, and Tim was dependent upon the professional competence of his surgeons to keep him alive. However, to the risk of staying alive, Tim assigned an added dimension of quality which enhanced the value of his continued living. The quality Tim assigned to his life, which seemed increasingly worthwhile, was the quality of belonging. "Belonging" represented the future of a promising life and richness through renewed relationships. Tim had grown emotionally close to his family, and their reciprocal response was evident. A fondness for Tim developed among the floor nurses, cardiac specialists and his attending physician. Tim would announce the story of his awakened life to all within earshot. In hearing these stories of his dreams and hopes, people understood Tim as a person.

Listeners of narratives are often befuddled about how to hear stories. They describe the task of interpreting stories much like fishing. In order to capture pure content or the "guts" of a person's story, there is confusion over whether they are using the right bait or whether they are casting their line in the right part of the lake. My experience with narratives is that people with purposeful stories are always throwing the fish into my boat, right in front of me! I do not need to chase after the fish, I merely need to recognize how storytelling works. Storytelling works with themes, not sound bites. The narrative themes represent the purpose of the telling, encased in the values and moral sensibilities that activate the story.

For the speaker, narrative is not random ramblings. For the listener, narrative is not careless eavesdropping. Narrative listening relies on a focused structure built around major spiritual themes. Narrative and spiritual assessment converge in the identification of these themes and the realization that an inherent relationship exists among them. The major spiritual value themes are: grief; significant stressors in a patient's life before and after surgery; how a patient makes meaning; what is the patient's sense of choice in the disease process; does the patient have a life project; what constitutes the identity in which the patient situates hope; what gives the patient's life purpose and worth? These themes exist on a spiritual level because the patient infuses them with a sense of ultimacy during hospitalization. Patients will devote more concentrated attention to grief issues during their stay in a hospital than all the previous years of their life!

It turned out that Tim did not strongly believe in the traditional concept of God, because his image of God was "out there," "outside his grasp," "beyond what he could

Stories are meant to bespeak a person's identity.

touch." In a parallel process, Tim's own inner life was "beyond his reach." He viewed himself in the role of an outward observer, always studying how to bring the world into his sphere of influence. Such attempts were often personally frustrating, as Tim's activity drifted toward others and away from his own substance. The language Tim used to describe God indicated that he was out of touch with his own inner life. To foster a journey of "reaching in" would bring Tim to know that people do not have to "reach out" to God, since God "reaches into" each of us, and to allow that to happen for himself. The bonus of discovering his inner emotional life was reflected in the mystery of how God lives within our depth. The threat of imminent death was not an occasion for "finding religion" so much as a spiritual awakening. Tim developed a capacity to believe in the value and quality of himself, in the significance and depth of his relationships, and in the spontaneity and satisfaction of his present time. Tim made peace with his past, and now the connection between present and future was more an opportunity than a threat! Tim began taking more active charge of his life, instead of passively waiting to see what would be done for him.

Tim discovered that inside the shared stories of his childhood were the "bits" of a hopeful future. Tim planted and harvested these "seeds" by living

out the rich possibilities of relationships. He took the fruitful opportunity for inner fulfillment before stepping into an uncertain future.

The pain encountered in grieving is the very energy that heals.

I did not realize how important this achievement was until a month later, when I was standing at the pulpit giving a eulogy at Tim's funeral. Tim had

elected bypass surgery. The aneurysm on the heart proved much larger than anticipated, and Tim suffered post-surgically from persistent bleeding. In the end, sepsis overcame his body and Tim died.

I share this story because of my own need for grieving and healing. As a hospital chaplain, I am satisfied that my interventions helped Tim attain great peace during his last days. At the moment when the medical "cure" did not work, Tim readied himself for healing. I miss my friend, but I "stand in" my sadness and "reach into" the emotions of this narrative to share my story.

Love, Loss and Legacy: Death and Dying in Children's Literature

by Eileen M. O'Connell

Readers unfamiliar with children's literature may be inclined to overlook its potential as a resource for discussions about dying and death. Everett Anderson's Goodbye, The Tenth Good Thing About Barney and Charlotte's Web are books written for children that explore these subjects and offer valuable insights to children and adults alike. A theme of love, loss and legacy operates in these and other children's books about death and dying. Exploring this dynamic offers one approach to coping with these issues.

To many people, children's literature may seem an unlikely forum for examining issues of dying and death. However, those familiar with children's books, from the simplest picture books to the most timely young adult novels, realize that literature for children is as attuned to the needs of its audience as is literature for adults. Contemporary as well as classic children's fiction provides insightful lessons about friendship, loneliness, fear, courage, compassion, honesty, perseverance, trust, discrimination, play, change, family, growth, aging, illness and death. Furthermore, children's literature is accessible to people from almost any age group and reading level and therefore enables a wide audience to discuss these issues.

Of the 141 titles currently listed under the subject heading "Death—fiction" in the Albuquerque Public Library's catalog, 137 are classified as children's books. Many of these are picture books which focus

on the death of parents (Everett Anderson's *Goodbye* by Lucille Clifton; *Saying Goodbye to Daddy* by Judith Vigna), grandparents (*Christmas Moon* by Denys Cazet; *Nana Upstairs, Nana Downstairs* by Tomie de Paola), friends (*Badger's Parting Gifts* by Susan Varley; *I Had a Friend Named Peter* by Janice Cohn), and pets (*The Tenth Good Thing About Barney* by Judith Viorst; *That Dog* by Nannette Newman). Furthermore, the catalog listing does not include works like E.B. White's *Charlotte's Web*, in which death is one issue in a wide context of relationships. When works such as *Charlotte's Web* are also examined, children's literature provides a comprehensive springboard for considerations of dying and death.

Eileen M. O'Connell is a circulation specialist with the Albuquerque/Bernalillo County Public Library System in Albuquerque, New Mexico.